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RESEARCH REPORT

National Prevalence of Mental Disorders among Federally Sentenced Women Offenders: In Custody Sample

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National Prevalence of Mental Disorders Among Federally Sentenced Women Offenders: In Custody Sample

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Executive Summary

Key words: Federally sentenced women offenders; lifetime and current prevalence of mental disorders; co-occurring disorders; Indigenous women

International studies estimate that as many as 80% of inmates in jails and prisons have a mental disorder, four times the rate found in the general population. Half are likely to have a co-occurring mental disorder with a substance abuse, or antisocial or borderline personality disorder. The literature suggests that the rate of mental disorder is two to four times greater among women inmates, who are typically more likely than men to have a major mental illness, borderline personality disorder, and posttraumatic stress disorder.

The current study determined the prevalence rates of mental disorders among women offenders currently in custody in CSC facilities. Using the Structured Clinical Interview for DSM Axis I and Axis II Disorders (SCID-I and SCID-II) the following disorders were assessed: 1) mood; 2) psychotic; 3) substance use; 4) anxiety; 5) eating; 6) pathological gambling; 7) Antisocial Personality Disorder (APD); and 8) Borderline Personality Disorder (BPD). Rates were obtained for both lifetime and current prevalence (i.e., the past month). Women in custody were approached to participate in the diagnostic interview from February 2016 to October 2016. In total, 154 women in six institutions from across the five regions provided consent and were included in the study.

Results indicated that almost 80% of federally sentenced women in custody meet the criteria for a current mental disorder, including high rates of alcohol and substance use, and APD and BPD. One-third has a current posttraumatic stress disorder. Nearly two-thirds of the women have had a major mental illness (major depression, bi-polar disorder or psychosis) in their lifetime and 17% have a current major mental illness. More than two-thirds have a co-occurring mental disorder with alcohol or substance misuse in combination with APD or BPD. One-third have a GAF score ≤ 50, indicating a serious level of impairment in daily functioning that could interfere with their capacity to actively engage in and benefit from mental health, rehabilitation and recidivism reduction programs and services. Indigenous women have the highest rates of mental disorder, including higher rates of alcohol and substance use disorders, APD and BPD, posttraumatic stress disorder, and higher rates of co-occurring disorders than non-Indigenous women.

The results from the study parallel the findings from international and other Canadian studies. In combination with their relatively small numbers dispersed across the country in six different institutions and five different regions, these high rates of disorder constitute a significant challenge in providing mental health treatment programs to these vulnerable women.

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Introduction

International studies estimate that between 20% - 80% of inmates in jails and prisons have a mental disorder, depending on the definition of mental disorder used, the instrument used to assess symptoms, and whether substance misuse or personality disorder are included in the definition of mental disorder (Andreoli et al., 2014; Brink, 2005; Butler, Indig, Allnutt & Mamoon, 2011; Keene & Rodriguez, 2005; Maccio et al., 2015; Proctor & Hoffmann, 2012; Senior et al., 2013), as much as four times the rate found in the general population (Fazel & Danesh, 2002; Prins, 2014; Sarteschi, 2013; Sirdifield, Gojkovicm, Brooker, & Ferriter, 2009; Steel et al., 2014). High rates of psychosis (3% - 4%), major depression (10% - 30%) and anxiety disorders (20% - 40%) are consistently reported in jail and prison mental health studies (Fazel & Seewald, 2012; Maccio et al., 2015; Prins, 2014; Senior et al., 2013; Vicens et al., 2011); rates of substance use disorders (70% - 80%) and personality disorders (50% - 80%) are as much as eight times greater than found in the general population (Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016; Proctor & Hoffmann, 2012; Sirdifield et al., 2009; Slade & Forrester, 2013). Estimates of co-occurring disorders among prison inmates, most frequently a mental disorder in combination with substance use or personality disorder, range from 20% to more than 50% (Butler et al., 2011; Fazel & Danesh, 2012; Proctor & Hoffman, 2012). The prevalence of mental disorder is two to four times greater among women than men inmates (Al-Rousan, Rubenstein, Sieleni, Deol, & Wallace, 2017; Baillargeon et al., 2009; Binswanger et al., 2010; Fazel et al., 2016; Prins 2014; Senior et al., 2013; Steadman, Osher, Robbins, Case, & Samuels, 2009). Compared to their male counterparts, female inmates are more likely to have been diagnosed with psychosis (4% - 12%), major depression (23% - 56%), bipolar disorder (2.5% - 20%), anxiety disorder (13% - 55%), borderline personality disorder (20% - 54%) and trauma-related disorders (11% - 40%). Men inmates demonstrate a greater frequency of antisocial personality disorder, impulse control disorders, and alcohol abuse (Andreoli et al., 2014; Baillargeon et al., 2009; Binswanger et al., 2010; Butler et al., 2011; Butler, Allnutt, Cain, Owens, & Muller, 2005; Coolidge, Marle, Van Horn, & Segal, 2011; Drapalski, Youman, Stuewig, & Tangney, 2009; Prins, 2014; Trestman, Ford, Zhang, & Wiesbrock, 2007; Tye & Mullen, 2006; Williams et al., 2010).

Canadian studies mirror the international findings, with reported estimates of the prevalence of mental disorder among provincial and federal inmates in the range of 20% - 80% (Beaudette & Stewart, 2016; Brown, Hirdes, & Fries, 2015; Lafortune, 2010; Rezansoff, Moniruzzaman, Gress, & Somers, 2013; Stewart, Wilton, & Cousineau, 2012), two to four times the rate found in the Canadian population (Pearson, Janz, & Ali, 2013; Public Health Agency of Canada, 2015). High rates of psychosis (3% - 9%), depression (10% - 69%), bi-polar disorder (1.5% - 25%), anxiety (17% - 40%), trauma-related disorders (4% -13%), antisocial personality disorder (44% - 83%) and substance misuse disorders (25% - 85%) are consistently reported in the Canadian research (Beaudette & Stewart, 2016; Brink, Doherty, & Boer, 2001; Brown et al., 2013; CIHI, 2008; Corrado, Cohen, Hart, & Roesch, 2000; Derkzen, Booth, McConnell, & Taylor, 2012; Lafortune, 2010; Motiuk & Porporino, 1991; Rezansoff et al., 2013; Stewart et al., 2012). In offender populations, recent estimates of the prevalence of co-occurring mental disorder with a substance abuse disorder exceed 50%, and rates of mental disorder co-occurring with an antisocial personality disorder are around 36% (Beaudette & Stewart, 2016). The prevalence of mental disorder is greater among women compared to men inmates, with women inmates in Canadian jails and prisons showing higher rates of psychosis (5% - 9%), depression (26% - 69%), anxiety (20% - 48%), personality disorder (28% - 83%) and trauma-related disorders (31% - 52%) (Blanchette & Motiuk, 1996; Brown et al., 2013; Derkzen et al., 2012; Lafortune, 2010). There is mixed evidence of a difference in the prevalence of mental disorder between Indigenous and non-Indigenous inmates, though higher rates of substance misuse disorder among Indigenous inmates are consistently reported (Beaudette, Power, & Stewart, 2015; Derkzen et al., 2012).

Men account for more than 90% of the incarcerated population, both in Canada and internationally (Walmsley, 2015); therefore, it is perhaps not surprising that research on the prevalence of mental disorder among offenders has, until recently, focused largely on male inmates and the need to provide mental health assessment and treatment services to this large segment of the inmate population (Drapalski et al., 2009; Fazel et al., 2016; MacDonald, 2013). However, rapid growth in the number of women being incarcerated internationally (estimated as increasing by more than 50% since 2000 (Walmsley, 2015) and in Canada by more than 50% since 2005 (Sapers, 2014), the greater prevalence of mental disorder among women inmates, and growing evidence of the importance of considering gender differences in the management and

treatment of mental disorder (Bartlett et al., 2015; Dalley, 2014; MacDonald, 2013; Schnittker & Bacak, 2016) point to the need for reliable estimates of the prevalence of mental disorder among women in custody in order to identify and develop management and treatment strategies that address the mental health problems of this small, and unique inmate population. To support CSC's mental health strategy (CSC, 2012) and its key principle that "*mental health services respond to the diverse backgrounds and needs of offenders, with particular emphasis on women and Aboriginal offenders*", it is important that accurate estimates of the prevalence of mental disorder among federally sentenced women, including Indigenous women, be determined to support the development and implementation of gender, and culturally appropriate mental health assessment and treatment services.

The current study employs the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I-RV/P; First, Spitzer, Gibbon, & Williams, 2007), and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997), generally regarded as the 'gold standard' of clinical research instruments, to interview a national sample of federally sentenced women offenders for the presence of symptoms and diagnoses of mental disorders and personality disorders. The current study complements the previous Correctional Service of Canada commissioned study *National Prevalence of Mental Disorders among Incoming Federally Sentenced Men Offenders* (Beaudette et al., 2015), but differs in methodology in that the women in the current study were not assessed at the intake unit, but rather, after they had been placed in custody.

Method

Participants

All women incarcerated in the six federal women's institutions across the five federal regions during the study period February 2016 – October 2016 were eligible to participate in the study. A breakdown of the total eligible inmate population, volunteer sample, and number of inmates who could not be contacted or declined to participate is shown in Table 1. Of the women actually contacted to participate in the study, only a small proportion (32/690; 4.6%) declined, or withdrew after beginning the clinical interview.

Table 1

Participants and non-Participants by Institution: National Sample (N = 154)

Institution	Total Count *n*	Participants *n* (%)	Unable to Contact/No Show *n* (%)	Declined/Withdrew *n* (%)
Fraser Valley Institution	112	29.5 (33)	0	20.5 (23)
Edmonton Institution	167	19.2 (32)	9.0 (15)	0.6 (1)
Okimaw Ohci Healing Lodge	44	38.6 (17)	0	2.3 (1)
Grand Valley Institution	171	20.5 (35)	19.9 (34)	0.6 (1)
Joliette Institution	115	14.8 (17)	0	5.2 (6)
Nova Institution	81	24.7 (20)	35.8 (29)	0
Total	690	22.3 (154)	11.3 (78)	4.6 (32)

Addendum note: Data from seven women in the Regional Psychiatric Centre were added to the in-custody sample after this report was completed. These data will be included in the final report (Prevalence of mental disorder among federally sentenced women: Intake and in-custody samples) that presents the results for both the in-custody and intake samples.

Overall, 22.3% (N = 154/690) of federal women inmates incarcerated during the study period participated in the study. The Joliette Institution for Women in the Quebec region had the lowest participation rate (14.8%); the highest rate of participation was at the Okimaw Ohci Healing Lodge (38.6%). The demographic and offender characteristics profile for the study participants is shown in Table 2.

Table 2

Characteristics of Participants (N = 154) and Non-Participants (N = 546)

	Sample Participants % (*n*)[a]	Population Non-Participants % (*n*)[b]	X^2	*df*
Ethnicity				
Aboriginal	32.8 (48)	38.5 (210)	4.50	3
Black	4.0 (6)	4.8 (26)		
White	57.0 (86)	47.1 (257)		
Other	7.3 (11)	9.3 (51)		
Marital status				
Single	50.0 (77)	54.9 (300)	1.21	3
Married/common-law	31.2 (48)	27.7 (151)		
Divorced, separated, or widowed	15.6 (24)	14.3 (78)		
Other	3.3 (5)	3.1 (17)		
Criminogenic need level (at intake)				
Low	11.0 (17)	6.6 (36)	6.32*	2
Medium	37.0 (57)	30.8 (168)		
High	52.0 (80)	61.4 (335)		
Criminal history risk level (at intake)				
Low	33.1 (51)	21.6 (118)	8.19*	2
Medium	35.1 (54)	40.7 (222)		
High	31.8 (49)	36.4 (199)		
Major admitting offence				
Homicide related	24.7 (38)	24.5 (134)	11.06[1]	6
Robbery	9.7 (15)	13.0 (71)		
Drug offences	31.8 (49)	25.5 (139)		
Assault	7.1 (11)	15.0 (82)		
Sexual offences	3.3 (5)	2.9 (16)		
Property offences	14.9 (23)	10.1 (55)		
Other violent offences	†	3.7 (20)		
Other non-violent offences	5.8 (9)	5.1 (28)		
Security level (at intake)				
Minimum	41.6 (64)	23.4 (128)	19.23***	2
Medium	42.2 (65)	55.3 (302)		
Maximum	16.2 (25)	20.3 (111)		
Sentence type				
Determinate	82.5 (127)	83.3 (455)	0.09	1
Indeterminate	17.5 (27)	16.5 (90)		
Average sentence length in years (SD)	3.7 (1.9)	3.8 (2.5)	t =0.418	580

†Information suppressed due to frequencies fewer than 5 in one category.

[a] n = 3 missing for variable 'Ethnicity' among sample participants

[b] n = 2 missing for variable 'Ethnicity' among comparison sample; n = 7 missing for 'Criminogenic need' and 'Criminal history'; n = 1 missing for 'Major admitting offence' and 'Sentence type'; n = 5 missing for 'Security level'

[1] chi-square calculated for 2 X 7 table due to low cell count for participants 'Other violent offences'

* $p < .05$, ** $p < .01$, *** $p < .001$

There are a number of statistically significant differences between the participant sample and the remaining population of federal women inmates who did not participate in the study. Sample participants demonstrated statistically significantly lower criminogenic need and criminal history risk levels at intake, and are also significantly more likely to be placed in minimum security. There was no difference between participants and non-participants in demographic factors (including age: 36 and 36 respectively, $t = 0.000$, $p = 1.00$), major admitting offence or sentence type, or average sentence length ($t = 0.418$, $p = 0.676$).

Given the relatively small sample size, institutional or regional comparisons of demographic and offender characteristics are not presented.

Measures/Material

Structured Clinical Interview for DSM-IV-TR Axis I and Axis II Disorders (SCID-I and SCID-II). The SCID-I is a semi-structured clinical interview designed for diagnosing DSM-IV1 Axis I mental disorders (First et al., 2007). The Research Version of the SCID-I/NP used in the current study is longer than the Clinician Version, as it contains more detailed information about specific disorders and their subtypes, and level of severity and methods of coding that is diagnostically useful for research purposes, and can be easily adapted to suit specific research objectives (Biometrics Research, 2017a). In the current study, the SCID-I/NP was used to assess the following disorders: 1) mood, 2) psychotic, 3) substance use, 4) anxiety, 5) eating, and 6) pathological gambling. The SCID-II (First et al., 1997) is a version of the SCID used to assess DSM-IV-TR Personality Disorders. Eleven different personality disorders are assessed, along with two additional provisional disorders (Biometrics Research, 2017c; Martin, 2014). In the current study, the SCID-II was used to assess for 7) anti-social personality disorder (APD) and 8) borderline personality disorder (BPD). Both lifetime and current prevalence (i.e., in the past month) of mental disorder was assessed where sufficient information was available to the interviewers. The SCID-I and SCID-II clinical interviews were completed in hardcopy, paper form.

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[1] DSM-IV-TR - Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision, (American Psychiatric Association, 2000)

The SCID and its various versions are widely considered to be the 'gold standard' for assessing DSM-IV-TR Axis I and Axis II disorders (Corrigan, Mueser, Bond, Drake, & Solomon, 2008; Shear et al., 2000), and a large body of research supports moderate to strong psychometric properties (reliability, validity, sensitivity, specificity) of the SCID I and SCID-II (Biometrics Research, 2017b; Chmielewski, Clark, Bagby, & Watson, 2015; DeMarce, Lash, Parker, Burke, & Grambow, 2013; Fennig, Craig, Lavelle, Kovasznay, & Bromet, 1994; Germans, Van Heck, Masthoff , Trompenaars, & Hodiamont, 2010; Lobbestael, Leurgans, & Arntz, 2011; Ryder, Costa, & Bagby, 2007; Zanarini & Frankenburg, 2001). 2

The SCID-I and SCID-II have been widely used internationally in community and institutional populations, including with psychiatric patients and offender populations (Chen, Chen, & Hung, 2016; Guy, Poythress, Douglas, Skeem, & Edens, 2008; Komarovaskaya, Booker Loper, & Warren, 2007; O'Brien, Mortimer, Singleton, & Meltzer, 2003; Roberts & Coid, 2010; Steadman, Robbins, Islam, & Osher, 2007; Trestman et al., 2007; Ullrich et al., 2008; Walter, Wiesbeck, Dittmann, & Graf, 2011; Wetterborg, Långströmb, Andersson, & Enebrink, 2015; Zimmerman, Ruggero, Chelminski, & Young, 2010), and with Canadian federal inmates (Beaudette & Stewart, 2016; Power & Beaudette, 2014; Power & Usher, 2011a, 2011b).

Modified Global Assessment of Functioning – Revised (GAF). To ensure consistency and comparability of results with the previous study of the prevalence of mental disorder among federally-sentenced male inmates (Beaudette et al., 2015), the GAF measure of symptom severity and global level of functioning was used in the current study. The GAF is perhaps the most widely used measure of psychological, social and occupational functioning in clinical and research settings, and by legal, administrative, and insurance organizations in making decisions regarding level of impairment and eligibility for treatment (Gold, 2014; Støre-Valen et al., 2015). Ratings on the GAF scale range from 90 (absent or minimal symptoms) to 0 (serious symptoms and functional impairment, danger to self or others, mental illness), with a GAF score of 50 or less representing serious symptoms or impairment of functioning (Hall, 1995; WHO, 2004). The

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[2] For a more in-depth review of the psychometric properties of the SCID-I and SCID-II, see Beaudette, Power, & Stewart (2015). *National prevalence of mental disorders among incoming federally-sentenced men offenders.* Ottawa, Ontario: Correctional Service of Canada.

GAF scale has been shown to have adequate reliability and validity (Rush et al., 2008; Söderberg, Tungström, & Åke Armelius, 2005; Smith et al., 2011), and can be easily administered with little training or clinical expertise.

Procedures/Analytic Approach

Research Design. The study was conducted under the terms of the Memorandum of Understanding (MOU) between the Correctional Service of Canada and the Institute for Applied Social Research (IASR) of the School of Criminology and Criminal Justice at Nipissing University. The Research Ethics Board at Nipissing University (NUREB) reviewed and approved the study according to the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*, including Chapter Nine – Research Involving the First Nations, Inuit and Métis Peoples of Canada (Government of Canada, 2014). Dr. Jane Barker and Kindra McMillan, the IASR Senior Research Assistant, and Rachel Norman, IASR Research Assistant were responsible for organizing the data collection, conducting the clinical interviews, and overseeing the data entry, data verification, and preliminary reporting of results. CSC organizational support for the study was provided by Interventions and Women Offenders Research and by the Aboriginal Initiatives Directorate.

A cross-sectional or 'snap shot' survey research design (Rothman, Greenland, & Lash, 2008) was used to estimate the prevalence of mental disorder among the federal women inmates. Owing to the national scope of the study and the six institutional sites involved in the research, the survey was conducted over an extended period, from February 2016 to October 2016.

Assessor Training. The IASR researchers were trained in the administration of the SCID-I and SCID-II instruments by completing five days of self-directed learning using the training package provided by Biometric Research (http://scid4.org/index.html), which included two user's manuals, two written case examples, and eight instructional DVD's. Upon completion of the training and throughout the course of the data collection, questions or concerns about the use of the instruments were recorded and discussed with the psychologist on the research team Dr. Barker, who had extensive prior experience in using mental health assessment instruments, and within the federal women's prison environment. To ensure consistency in completion of the SCID instruments, two members of the research team were present at each of the first twenty clinical interviews completed. The pairing of the researchers in teams of two at each of the institution sites further ensured that any questions about the scoring of the instruments could be

immediately addressed.

Participant Recruitment. Beginning February 2016, members of the research team began visits on a rotating basis to each of the six federal women's institutions in Canada. In advance of each visit, an information letter was sent by the Director, Research Branch CSC to the Warden of the institution, explaining the research and asking for an on-site contact to be designated to assist the IASR researchers in making the arrangements to conduct the research. Upon arriving at each institution, the IASR researchers would meet with the designated on-site contact to review the arrangements and any institutional requirements, to provide any clarification or additional information if required, and to meet with the on-site Elder if available.

A systematic sampling strategy (Bruce, Pope, & Stanistreet, 2008) was used to identify potential participants for the study. With the assistance of the on-site contact, the IASR researchers chose every third name on the institutional roster of inmates, and contacted that inmate, in person or by institutional telephone, to explain the study and to request their participation. A total of $N = 154$ women (22.3% of the total federal female inmate population) volunteered to participate and fully completed the interviews; 78 of the women contacted (11.3% of total population) could not be reached or did not return a telephone call or did not show up for an arranged interview; 32 women (4.6% of total population) declined to participate or did not complete the interview. Throughout the course of each of their on-site visits, the IASR researchers continued the systematic sampling strategy, until the time allotted for the visit came to an end. Larger institutions (Grand Valley and Edmonton) were visited twice. Data collection was completed in October 2016.

Informed Consent and Data Management. No compensation or incentive was provided in return for participating in the study. The IASR researchers provided inmates who volunteered to participate with a verbal summary of the informed consent form, and encouraged inmates to ask questions about the procedures to be employed and the terms of their participation. All participants were then asked to sign a hardcopy of the informed consent form prior to proceeding with the SCID interviews, which included a request for permission to access their offender management system (OMS) file for the purpose of the research. Debriefing procedures were outlined on the consent form. Interviews were conducted in English at the Nova, Grand Valley, Edmonton and Fraser Valley institutions and Okimaw Ohci Healing Lodge, and in French or English at the Joliette institution. As the SCID-I and SCID-II assessments were used for research

not diagnostic purposes, the results were not shared with the participants.

The SCID-I and SCID-II clinical interviews were completed in hardcopy, paper form. A unique study participant identifier number was created so that inmate names and FPS numbers were not recorded on the completed clinical interviews, but rather kept in a separate, secure file location accessible only to the IASR Senior Research Assistant. Completed interviews were returned by the IASR researchers to Nipissing University, and kept in a locked filing cabinet in a secure office. An IASR student research assistant entered the completed interview data into the IBM SPSS Statistics 24 (IBM Corporation, 2016) program for the purposes of the data analysis. A merged data file, which combined the SCID-I and SCID-II data with inmates' demographic and offender characteristics, was created by the CSC Interventions and Women Offenders Research staff for the purposes of the data analysis and reporting of results.

Statistical Techniques. Chi-square analyses and Student's t-tests of differences between means were conducted to identify statistically significant differences between the participant sample and the comparison non-participant sample, and to test differences in the distribution of GAF scale scores based on Indigenous ancestry. Estimates of the lifetime and current prevalence of mental disorder were calculated by dividing the number women inmates meeting the diagnostic criteria for a particular disorder (or group of disorders) by the total sample size (N = 154). As the sample of women federal inmates is small, no comparative data by institution or region are shown, and estimates of the prevalence of mental disorder and comparisons of differences between female and male prevalence rates should be interpreted with serious caution using the current methodology. An upcoming second study, assessing women at intake, will provide solid comparisons between incoming men and women.

Results

Prevalence of Mental Disorders among Federally Sentenced Women

The prevalence rates of mental disorders for the national sample of incarcerated federally sentenced women ($N = 154$) are presented in Table 3.

Table 3
Prevalence Rates of Mental Disorders among Federal Women Offenders: In Custody Sample (N = 154)

Disorder	Lifetime % (*n*)	Current % (*n*)
Any disorder	**92.9 (143)**	**79.2 (122)**
Mood disorders	**61.7 (95)**	**22.1 (34)**
Bi-polar disorders[a]	10.4 (16)	4.5 (7)
Major depressive disorder	46.8 (72)	9.7 (15)
Dysthymic disorder	9.7 (15)	9.1 (14)
Mood Disorders – other[b]	7.8 (12)	†
Psychotic disorders[c]	**7.1 (11)**	**4.5 (7)**
Alcohol and substance use disorders (life time only)	**76.0 (117)**	-
Alcohol abuse or dependence	48.7 (75)	-
Non-alcohol substance abuse or dependence	72.1 (111)	-
Anxiety disorders	**57.1 (88)**	**53.9 (83)**
Panic disorder	18.8 (29)	14.3 (22)
Phobias[d]	18.8 (29)	17.5 (27)
Obsessive-compulsive disorder	10.4 (16)	10.4 (16)
Posttraumatic stress disorder	34.4 (53)	33.1 (51)
Generalized anxiety disorder	13.6 (21)	13.0 (20)
Anxiety Disorders – other[e]	7.1 (11)	7.1 (11)
Eating disorders	**16.2 (25)**	**11.0 (16)**
Anorexia Nervosa	5.8 (9)	†
Bulimia Nervosa	6.5 (10)	5.8 (9)
Binge-eating disorder	3.9 (6)	†
Pathological gambling	**13.6 (21)**	†
Borderline personality disorder (lifetime only)	**33.1 (51)**	-
Antisocial personality disorder (lifetime only)	**49.4 (76)**	-

Note. Percentages may not add to 100% as participants could meet the diagnostic criteria for more than one disorder. Percentages may vary due to missing data for some diagnoses (i.e. denominators may vary).

† Information suppressed due to frequency fewer than 5 in one category.

[a] Bi-polar disorders include bi-polar I disorder, bi-polar II disorder and other bi-polar disorder; [b] Mood disorders - other include depressive disorder not otherwise specified, mood disorder due to a general medical condition, substance-induced mood disorder; [c] Psychotic disorders include schizophrenia, schizophreniform, schizoaffective, delusional disorder, brief psychotic disorder, substance abuse or general medical condition causing psychotic symptoms, substance induced psychotic disorder, and psychotic disorder not otherwise specified; [d] Phobias include agoraphobia without history of panic, social phobia and specific phobia; [e] Anxiety disorders include anxiety disorder due to a general medical condition, substance-induced anxiety disorder and anxiety disorder not otherwise specified.

For the purposes of analysis and discussion, and as a consequence of the very small

numbers of women reported for many of the differential diagnostic categories, only major categories of mental disorder and grouped differential diagnostic categories are presented here. Prevalence rates for major categories of mental disorder are presented in bold, followed by rates for the grouped diagnostic categories. Major categories of mental disorder prevalence rates represent the percentage of inmates with at least one diagnosis within the major category. Complete results for major categories and all differential diagnostic categories are shown in Appendix A. Only lifetime prevalence of alcohol or substance use disorder is reported as it was not possible to validly assess current use among the incarcerated women.

In line with previous international and Canadian studies, federally sentenced women offenders demonstrated a higher lifetime and current prevalence of psychotic disorders (L: 7.1%; C: 4.5%), mood disorders (L: 61.7%; C: 22.1%) including major depression (L: 46.8%; C: 9.7%), anxiety disorders (L: 57.1%; C: 53.9%), posttraumatic stress disorder (L: 34.4%; C: 33.1%) and borderline personality disorder (L: 33.1%), in the order of four times greater than reported general population rates (Public Health Agency of Canada, 2015; Steel et al., 2014), and one and a half to two times greater than reported among men inmates (Lafortune, 2010; Prins, 2014; Schnittker & Bacak, 2016; Steadman et al., 2009). Estimates of the lifetime prevalence of alcohol (L: 48.7) and substance use (L: 72.1%) disorders are two to eight times greater than reported in the general population (Fazel et al., 2016; Fazel, Bains, & Doll, 2006; Pearson et al., 2013).

A breakdown of the prevalence of mental disorders among the sample of federally sentenced women by Indigenous and non-Indigenous ancestry, for major categories of mental disorder and grouped differential diagnostic categories, is shown in Appendix B. Owing to the very small/zero number of Indigenous women reported in many of the diagnostic categories, the results should be interpreted with caution. Almost without exception, the prevalence of mental disorders is greater among Indigenous women compared to their non-Indigenous counterparts. The prevalence of psychotic disorders, alcohol and substance abuse disorders and anxiety and eating disorders is greater among Indigenous women, along with pathological gambling and antisocial and borderline personality disorders. As almost the lone exception, Indigenous women evidence a lower prevalence of mood disorders overall, though current prevalence of major depressive disorder is still greater than among non-Indigenous women. In an Australian study, Butler, Allnutt, Kariminia, and Cain (2007) also reported a higher prevalence of mental disorders

generally among Indigenous Australian women compared to non-Indigenous women inmates, though more recently, using the PAI, Derkzen et al., (2012) observed almost no difference between Indigenous and non-Indigenous women inmates in Canadian federal custody, except in relation to substance abuse.

Overall, the prevalence rates of mental disorder among the national sample of federally sentenced women parallel the findings from other international and Canadian research: women inmates have higher lifetime and current rates of mental disorder compared to the general population and compared to male inmates; they are more likely to have symptoms of major depression, psychosis, anxiety disorder, posttraumatic stress disorder and borderline personality disorder, accompanied by high rates of alcohol and substance misuse.

Prevalence Rates of Mental Disorder and Major Mental Illness

For legal, diagnosis and treatment purposes (Hoge, Greifinger, Lundquist, & Mellow, 2009; Magaletta, Diamond, Faust, Daggett, & Camp, 2009; Reingle Gonzalez, & Connell, 2014; Sarteschi, 2013), recent studies of mental disorder in correctional inmate populations distinguish between major mental illness, substance abuse, and personality disorder as different disorders requiring generally distinct treatment and institutional management responses (Baillargeon et al., 2009; Brandt, 2012; Fazel & Seewald, 2012; Steadman et al, 2009).

Lifetime and current prevalence rates for any mental disorder, with and without alcohol and substance use or antisocial or borderline personality disorders included, are reported for the national sample of federally sentenced women (N =154) in Table 4, accompanied by lifetime and current estimates of the prevalence of major mental illness (major depressive disorder, bi-polar disorder or psychotic disorder) not including alcohol, substance use or personality disorders (if they are the only mental disorders).

More than ninety percent of women in the sample met the criteria for any mental disorder during their lifetime, and nearly eighty percent met the criteria for any current mental disorder.

Table 4

Prevalence Rates of Any Mental Disorder and Major Mental Illness among Federally Sentence Women Offenders: In Custody Sample (N = 154)

	% (n)
Criteria met for any disorder – lifetime	92.9 (143)
Criteria met for any disorder – current	79.2 (122)
Any disorder not including APD or BPD only	
Criteria met– lifetime	90.9 (140)
Criteria met– current	61.0 (94)
Any disorder not including alcohol/substance use disorders only	
Criteria met– lifetime	87.0 (134)
Criteria met– current[a]	78.6 (121)
Any disorder not including APD or BPD or alcohol/substance use disorder only	
Criteria met– lifetime	83.8 (129)
Criteria met– current	60.3 (93)
Rates of major mental illness[b] – lifetime	60.3 (93)
Rates of major mental illness[b] – current	16.9 (26)

Note. APD = Antisocial personality disorder; BPD = Borderline personality disorder.
Note: Reference to these calculations not including SUD or APD or BPD does not mean that women with these disorders were not included but rather that that they were not contributing to the prevalence considered if the ONLY diagnosis was for these disorders.
[a] Rates of current alcohol/substance use disorder could not be validly assessed given that women are in-custody when they participated in the study.
[b] Major mental illness corresponds to a diagnosis of any one of the following: major depressive disorder, bi-polar I disorder, bi-polar II disorder, or any psychotic disorder.

When alcohol or substance use disorders and antisocial personal disorder (APD) and borderline personal disorders (BPD) are not included as the only diagnoses, rates of lifetime (83.8%) and current (60.3%) mental disorder are still very elevated. On the other hand, lifetime (60.3%) and current (16.9%) prevalence rates for conditions generally defined as major mental illnesses representing serious impairments of functioning are substantially lower though, again, still elevated relative to community samples (Beaudette, & Stewart, 2016; Derkzen et al., 2012; Fazel & Seewald, 2012; Lynch et al., 2014; Prins, 2014; Senior et al., 2013, Stewart et al., 2012).

The breakdown of prevalence rates of mental disorder and major mental illness among Indigenous and non-Indigenous federally sentenced women is shown in Table 5. All (100%) Indigenous women met the criteria for a diagnosis of a mental disorder at some point in their

lifetime, and almost all (95.8%) have a current diagnosis of a mental disorder. Compared to the non-Indigenous women, Indigenous women demonstrated higher lifetime and current prevalence rates for any mental disorder, with and without alcohol and substance use disorders and personality disorders included. However, the lifetime prevalence of major mental illness is higher among non-Indigenous women, and rates of current major mental illness do not significantly differ (18.8% compared to 16.0%; see Table 5)

Table 5

Prevalence Rates of Any Mental Disorder and Major Mental Illness in Indigenous and non-Indigenous Federal Women Offenders: In-Custody Sample N = 154

	Indigenous *N* = 48 % (*n*)	Non-Indigenous *N* = 106 % (*n*)
Criteria met for any disorder – lifetime	100 (48)	89.6 (95)
Criteria met for any disorder – current	95.8 (46)	71.7 (76)
Any disorder not including APD or BPD only		
Criteria met– lifetime	93.8 (45)	89.6 (95)
Criteria met– current	66.7 (32)	58.5 (62)
Any disorder not including alcohol/substance use disorders only		
Criteria met– lifetime	95.8 (46)	83.0 (88)
Criteria met– current[a]	93.8 (45)	71.7 (76)
Any disorder not including APD or BPD or alcohol/substance use disorder only		
Criteria met– lifetime	85.4 (41)	83.0 (88)
Criteria met– current	64.6 (31)	58.5 (62)
Rates of major mental illness[b] – lifetime	54.2 (26)	63.2 (67)
Rates of major mental illness[b] – current	18.8 (9)	16.0 (17)

Note. APD = Antisocial personality disorder; BPD = Borderline personality disorder. [a] Rates of current alcohol/substance use disorder could not be validly assessed given that women are in-custody when they participated in the study. [b] Major mental illness corresponds to a diagnosis of any one of the following: major depressive disorder, bi-polar I disorder, bi-polar II disorder, or any psychotic disorder.

Prevalence of Co-occurring Disorders

International and Canadian studies report that as many as half of correctional inmates have a mental disorder co-occurring with a substance use or a personality disorder (Beaudette & Stewart, 2016; Fazel & Danesh, 2012; Proctor & Hoffman, 2012), with women demonstrating higher rates of co-occurring disorders compared to men (Al-Rousan et al., 2017; Butler et al., 2011; Houser & Welsh, 2014). Co-occurring disorders complicate treatment and institutional management responses to mental disorder and recovery, often leading to poorer outcomes for inmates, including increased recidivism (Fazel et al., 2016; Wilton & Stewart, 2012). The prevalence of lifetime mental disorder co-occurring with alcohol and substance use and personality disorders, by Indigenous and non-Indigenous ancestry and for the total sample (N = 154) is shown in Table 6.[3]

Table 6
Co-occurring Disorders among Federal Women Offenders: In-Custody Sample (N = 154)

	Indigenous n = 48 % (n)	Non-Indigenous n = 106 % (n)	Total Sample N =154 % (n)
Lifetime prevalence rates	n = 48	n= 95	n = 143
Any mental disorder and alcohol/substance use[a]	89.6 (43)	77.9 (74)	81.8 (117)
Any mental disorder and APD or BPD	87.5 (42)	51.6 (49)	63.6 (91)

Note. APD = Antisocial Personality Disorder; BPD = Borderline Personality Disorder
[a] Rates of current substance use were limited given that women are in-custody when they participated in the study; therefore, substance abuse and alcohol use disorders diagnoses rely on lifetime estimates only. Rates of current alcohol/substance use disorder could not be validly assessed given that women are in-custody when they participated in the study.

Overall, the estimates of lifetime prevalence rates for co-occurring disorders are in line with other international and Canadian research. Co-occurring mental disorders with alcohol and substance use disorders, almost always in combination with APD and BDP, are characteristic of more than eighty percent of federal women inmates with mental health problems. Research

[3] As APD and BPD were assessed for lifetime occurrence only, and as it was only possibly to validly assess alcohol and substance use disorders for lifetime occurrence. This does not mean that women with substance abuse disorders were not included but rather that that they were not considered if the ONLY diagnosis was for these disorders. The same is true of APD calculations

examining men found that those with co-occurring disorders had an increased likelihood of institutional infractions and less positive outcomes on release (Lynch et al., 2014; Priester et al., 2016; Wilton & Stewart, 2012). The confluence of mental disorder with either alcohol/substance use disorders and APD or BPD represents a significant challenge to delivering effective mental health treatment to inmates (Mir et al., 2015; Priester et al., 2016). Lifetime prevalence rates for co-occurring disorders are higher among Indigenous women in the sample where mental disorder is co-occurring with alcohol and substance use disorders in combination with APD and BDP.

Mental Disorder and Global Assessment of Functioning (GAF)

The modified version of the global assessment of functioning (GAF) scale scores provide a measure of the current level of psychological, social, and occupational impairment. Grouped GAF scale scores for the national sample of federally sentenced women, by DSM-IV Axis I and Axis II – APD and BPD personality disorder dimensions are shown in Table 7. A GAF score of 50 or less is considered to represent serious symptoms of mental disorder and/or impairment of functioning (Hall, 1995; WHO, 2004). Complete GAF scale score results for the national sample are shown in Appendix C.

Nearly two-thirds (61.3%) of women with a current Axis I diagnosis were scored as having none to moderate impairment stemming from their mental disorder, indicating a reasonably good level of functioning in their daily life. Similarly, among women with a diagnosis of APD or BPD only, the majority (94.4% and 66.7% respectively) demonstrate a good level of functioning. On the other hand, among women with both an Axis I and either APD or BPD, nearly half (49.2%) demonstrated serious impairment in daily functioning (GAF $\leq$ 50). It should be noted that the numbers in Table 7 only account for individuals who met the criteria for a current Axis I disorder (without alcohol or substance use included if they were the only diagnosis) or APD or BPD (if they were the only diagnosis).

Table 7

GAF Scale Scores by Mental Disorder for Current Personality Disorder Diagnoses: In-Custody Sample (N = 154)

GAF Score	Axis I[a] Disorders $n = 93$ % (n)	APD only $n = 18$ % (n)	BPD only[a] $n = 3$ % (n)	Axis I & APD or BPD $n = 63$ % (n)
51-90 - moderate to absent	61.3 (57)	94.4 (17)	66.7 (2)	50.8 (32)
1-50 – some serious to immediate danger to self	38.7 (36)	5.6 (1)	33.3 (1)	49.2 (31)

Note. GAF = Global Assessment of Functioning. [a]Excluding alcohol and substance use disorders if they are the only disorders in Axis I.

The GAF scale scores for a current major mental illness (major depression, bi-polar disorder I, bi-polar disorder II or psychotic disorder) are reported for the national sample of federally sentenced women (N =154) in Table 8. Among women with a current major mental illness, 69.2% (18/26) demonstrate a serious level of impairment in daily functioning; this group represents 11.7% (18/154) of the total national sample of federally sentenced women. More than one-third (35/93 = 37.6%) of women with either a major mental illness or APD or BPD evidence a serious level of impairment in daily functioning; this accounts for 22.7% % (35/154) of the national sample.

Table 8

GAF Scale Scores ≤ 50, by Categories of Mental Disorder: In-Custody Sample (N = 154)

	$N = 154$ GAF scores ≤50 % (n)
Major mental illness[a] ($n = 26$)	11.7 (18/154)
Either major mental illness or BPD or APD ($n = 93$)	22.7 (35/154)
Either major mental illness or BPD ($n = 61$)	20.8 (32/154)
Any Axis I disorder (excluding alcohol and substance abuse if they are the only disorders) ($n = 93$)	23.4 (36/154)

[a]Major mental illness corresponds to a diagnosis of any one of the following: major depressive disorder, bi-polar I disorder, bi-polar II disorder, or any psychotic disorder.

Overall, for all of the women offenders participating in the study with any current mental

disorder, 32.8% (40/122) demonstrated at least some serious symptoms or impairment in functioning.

Grouped GAF scale cut-off scores, by Indigenous ancestry, are shown in Table 9. Though the percentage of Indigenous women offenders with a GAF score ≤ 50 is greater than for non-Indigenous inmates, there is no statistically significant difference (X^2 (1, n = 154) = 1.964, p = 0.161) between level of impairment as measured by the GAF scale and Indigenous status.

Table 9

GAF Scale Scores by Indigenous Ancestry: In-Custody Sample (N = 154)

Level of Impairment (GAF score)	Indigenous n = 48 % (n)	Non-Indigenous n = 106 % (n)	Total Sample N=154 % (n)
51-90 - moderate to absent	66.7 (32)	77.4 (82)	74.0 (114)
1-50 – some serious to immediate danger to self	33.3 (16)	22.6 (24)	26.0 (40)

Note: Lower scores indicate greater impairment

Discussion

Studies estimating the prevalence of mental disorder among prison inmates can provide important information both about the number of inmates with mental health problems currently in the prison population, and the severity and complexity of the mental health problems supporting organizational responses to treatment and management (Baillargeon et al., 2009; Prins, 2014; Reingle Gonzalez, & Connell, 2014; Sarteschi, 2013). A body of international research suggests that the prevalence of mental disorders among prisoners is as much as four times the rate in the general population. High rates of psychosis, major depression, and anxiety disorders are combined with substance use or personality disorders in as many as half of inmates who have a mental health problem. Studies typically show that women inmates have a prevalence rate of mental disorders two to four times greater than men.

A growing body of Canadian research has found estimates of mental disorder among inmates that are similar to international findings. Compared to the general Canadian population, the prevalence of mental disorders among inmates is two to four times higher, with more than half of inmates meeting diagnostic criteria for a co-occurring substance use disorder, and more than one-third for a co-occurring personality disorder (Pearson et al., 2013; Public Health Agency of Canada, 2015). All (100%) of Indigenous women inmates who participated in the current national study demonstrated the criteria for a lifetime diagnosis of a mental disorder, and almost all (95.8%) have a current diagnosis of a mental disorder. Indigenous women evidenced higher rates of mental disorders, alcohol and substance use and antisocial and borderline personality disorders compared to non-Indigenous women.

Among the federally sentenced women, co-occurring mental disorders and alcohol/substance disorders (L:81.8%) %) or personality disorders (L: 63.6%) were at least four times greater than the prevalence rate observed in an Ontario population study (Rush & Koegl, 2008). The high prevalence of co-occurring mental disorders among federal women inmates may pose significant challenges to the design and implementation of effective treatments and programs that address both the mental health and criminogenic components of complex co-occurring disorders. Furthermore, the prevalence of co-occurring disorders, alcohol and substance misuse in combination with a personality disorder, is higher among Indigenous compared to non-Indigenous women inmates. The relatively small number of federally sentenced

women (690/14, 203 = 4.9% of the federal offender population; Public Safety Canada, 2016) spread out across the country in six facilities over five regions, their high current rates of mental disorders and co-occurring disorders, make it challenging to deliver the effective mental health treatment services and correctional interventions the women require.

The results of the modified version of the Global Assessment of Functioning (GAFm) scale show that, overall, among women offenders with any current mental disorder, 32.8% (40/122) demonstrated at least some serious symptoms or impairment in functioning. More than two-thirds (18/26 = 69.2%; or, 11.7% of the total national sample) of women with a major mental illness demonstrate a serious level of impairment in daily functioning (GAF $\leq$ 50) that could have an impact on their capacity to actively engage in and benefit from mental health, rehabilitation, and recidivism reduction programs and services. There were no statistically significant differences in GAF scale scores between Indigenous and non-Indigenous federally sentenced women. Federally sentenced women in this study demonstrated higher mean GAF scores overall ($\bar{x}$ = 63.81) compared to psychiatric hospital patients (Mean = 31.88 admission: Mean = 47.72 at discharge; Vatnaland, Vatnaland, Friis, & Opjordsmoen, 2007) and community mental health patients (Mean = 61.24; Tungström, Söderberg, & Armelius, 2005).

Limitations of the Study

Compared to federally sentenced women (N = 546) who did not participate in the study during the study period (see Table 2) the women who participated in the study (N = 154) demonstrated statistically significantly lower intake criminogenic need and risk levels and were also significantly more likely to be placed in minimum security at intake. This could possibly attenuate estimates of the prevalence of mental disorder, given that higher risk women may be more likely have symptoms of a mental disorder. At the same time, the most severely mentally ill women receiving treatment in specialized mental health units, and women in administrative segregation or those deemed too great a risk to participate, were not eligible to participate in this component of the study[4], possibly contributing to an underestimation of the extent of mental

[4] Data collection at the Regional Psychiatric Centre, the facility that houses women requiring intensive psychiatric treatment is scheduled for December 2017.

disorder in this population.

The national scope of the study dictated that conducting the SCID interviews with the study participants had to take place over an extended period of time (February 2016 – October 2016), possibly introducing 'historical' biases (changes in organizational practices, sentencing criteria, high profile media) into the recruitment and assessment of participants.

Owing to the relatively small sample size ($N = 154$), it was not possible to examine regional or institutional differences in the prevalence of mental disorder among federally sentenced women. The national study of the prevalence of mental disorder among federal male inmates suggested that there were significant differences in the regional prevalence of mental disorders, substance and alcohol disorders and personality disorders, along with differences in GAF scale scores.

Nevertheless, use of the SCID-I and SCID-II instruments, considered to be the 'gold standard' for the assessment of mental disorders, coupled with the strong consistency of the results of the current study with previous international and Canadian research, provide evidence that the current results are reliable and valid estimates of the prevalence of mental disorders among federally sentenced women.

Conclusions

The prevalence of mental disorders is much greater among women inmates in CSC than in the general population, and greater than reported in previous international and Canadian studies of men inmates. Indigenous women appear to have higher rates of many mental disorders, and higher lifetime rates of co-occurring disorders with alcohol and substance use and antisocial and borderline personality disorders. This, in combination with their relatively small numbers dispersed across the country in six different institutions across five regions, present significant challenges to the provision of effective mental health and correctional treatment programs for incarcerated women.

References

Al-Rousan, T., Rubenstein, L., Sieleni, B., Deol, H., & Wallace, R. B. (2017). Inside the nation's largest mental health institution: A prevalence study in a state prison system. *BMC Public Health, 17*, 1-9. doi: 10.1186/s12889-017-4257-0

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: American Psychiatric Association.

Andreoli, S. B., Mendes dos Santos, M., Quintana, M. I., Ribeiro, W. S., Blay, S. L., Taborda, J. G. V., & de Jesus Mari, J. (2014). Prevalence of mental disorders among prisoners in the state of Sao Paulo, Brazil. *PLOS ONE, 9*(2), 1-7. doi:10.1371/journal.pone.0088836

Baillargeon, J., Penn, J. V., Thomas, C. R., Temple, J. R., Baillargeon, G. & Murray, O. J. (2009). Psychiatric disorders and suicide in the nation's largest state prison system. *Journal of the American Academy of Psychiatry and the Law*, *37*(2), 188-193.

Bartlett, A., Jhanji, E., White, S., Harty, M. A., Scammell, J., & Allen, S. (2015). Interventions with women offenders: A systematic review and meta-analysis of mental health gain. *Journal of Forensic Psychiatry & Psychology*, *26*(2), 133-165. doi: 10.1080/14789949.2014.981563

Beaudette, J. A., Power, J., & Stewart, L. A. (2015). *National prevalence of mental disorders among incoming federally-sentenced men offenders* (Research Report, R-357). Ottawa, ON: Correctional Service of Canada.

Beaudette, J. A., & Stewart, L. A. (2016). National prevalence of mental disorders among incoming federally-sentenced men offenders. *Canadian Journal of Psychiatry*, *61*(10), 624-632. doi: 0706743716639929

Binswanger, I. A., Merrill, J. O., Krueger, P. M., White, M. C., Booth, R. E., & Elmore, J. G. (2010). Gender differences in chronic medical, psychiatric, and substance-dependence disorders among jail inmates. *American Journal of Public Health*, *100*(3), 476-482. doi: 10.2105/AJPH.2008.149591.

Biometrics Research (2017a). *SCID-I/NP: Research Version.* Retrieved on June 12, 2017 from http://www.scid4.org/faq/research_version.html

Biometrics Research (2017b). *Structured Clinical Interview for DSM-IV-TR Avis II Personality Disorders (DSCID-II).* Retrieved on June 12, 2017 from http://www.scid4.org/faq/scid_2.html

Biometrics Research (2017c). *Psychometrics.* Retrieved on June 12, 2017 from http://www.scid4.org

Blanchette, K., & Motiuk, L. L. (1996). *Female offenders with and without major mental health problems: A comparative investigation* (Research Report R-46). Ottawa, ON: Correctional Service of Canada.

Brandt, A. L. S. (2012). Treatment of persons with mental illness in the criminal justice system: A literature review. *Journal of Offender Rehabilitation*, *51*(8), 541-558.

doi: 10.1080/10509674.2012.693902

Brink, J. (2005). Epidemiology of mental illness in a correctional system. *Current Opinion in Psychiatry, 18*(5), 536-541. doi: 10.1097/01.yco.0000179493.15688.78

Brink, J. H., Doherty, D., & Boer, A. (2001). Mental disorder in federal offenders: A Canadian prevalence study. *International Journal of Law and Psychiatry, 24*(4), 339-356. doi: 10.1016/S0160-2527(01)00071-1

Brown, G. P., Hirdes, J. P., & Fries, B. E. (2013). Measuring the prevalence of current, severe symptoms of mental health problems in a Canadian correctional population. *International Journal of Offender Therapy and Comparative Criminology, 59*(1), 27-50. doi: 10.1177/0306624X13507040

Bruce, N., Pope, D., & Stanistreet, D. (2008). *Quantitative methods for health research*. West Sussex, UK: John Wiley.

Butler, T., Allnutt, S., Cain, D., Owens, D., & Muller, C. (2005). Mental illness in the New South Wales prisoner population. *Australian and New Zealand Journal of Psychiatry, 39*(5), 407-413. doi: 10.1080/j.1440-1614.2005.01589.x

Butler, T., Allnutt, S., Kariminia, A., & Cain, D. (2007). Mental health status of Aboriginal and non-Aboriginal Australian prisoners. *Australian and New Zealand Journal of Psychiatry, 41*(5), 429-435. doi: 10.1080/00048670701261210

Butler, T., Indig, D., Allnutt, S., & Mamoon, H. (2011). Co-occurring mental illness and substance use disorder among Australian prisoners. *Drug and Alcohol Review, 30*(2), 188-194. doi: 10.1111/j.1465-3362.2010.00216.x

Chen, Y. Y., Chen, C-Y., & Hung, D. L. (2016). Assessment of psychiatric disorders among sex offenders: prevalence and associations with criminal history. *Criminal Behaviour and Mental Health, 26*(1), 30-37. doi: 10.1002/cbm.1926

Chmielewski, M., Clark, L. A., Bagby, R. M., & Watson, D. (2015). Method matters: Understanding diagnostic reliability in DSM-IV and DSM-5. *Journal of Abnormal Psychology, 124*(3), 764-769. doi: 10.1037/abn0000069.

CIHI (2008). *Improving the health of Canadians: Mental health, delinquency and criminal activity*. Ottawa, ON: Canadian Institute for Health Information.

Coolidge, F. L., Marle, P. D., Van Horn, S. A., & Segal, D. L. (2011). Clinical syndromes, personality disorders, and neurocognitive differences in male and female inmates. *Behavioral Sciences and the Law, 29*(5), 741-751. doi: 10.1002/bsl.997

Corrado, R. R., Cohen, I., Hart, S., & Roesch, R. (2000). Comparative examination of the prevalence of mental illness among jailed inmates in Canada and the United States.

International Journal of Law and Psychiatry, 23(5), 633-647. doi: 10.1016/S0160-2527(00)00054-6

Corrigan, P. W., Mueser, K. T., Bond, G. R., Drake, R. E., & Solomon, P. (2008). *Principles and practice of psychiatric rehabilitation: An empirical approach*. New York, NY: Guilford Press.

Correctional Service of Canada (2012). *Toward a continuum of care: Correctional Service of Canada's Mental Health Strategy*. Ottawa, ON: Correctional Service of Canada.

Dalley, L. P. (2014). From asylums to jails: The prevailing impact on female offenders. *Women & Criminal Justice, 24*(3), 209-228. doi: 10.1080/08974454.2014.924352

DeMarce, J. M., Lash. S. J., Parker, J. D., Burke, R. S., & Grambow, S.C. (2013). Validity of the Structured Clinical Interview for DSM-IV among veterans seeking treatment for substance use disorders. *International Journal of Mental Health Addiction, 11*(5), 546–556. doi: 10.1007/s11469-013-9435-4

Derkzen, D., Booth, L., McConnell, A., & Taylor, K. (2012). *Mental health needs of federal women offenders* (Research Report R-267). Ottawa, ON: Correctional Service of Canada.

Drapalski, A. L., Youman, K., Stuewig, J., & Tangney, J. (2009). Gender differences in jail inmates' symptoms of mental illness, treatment history and treatment seeking. *Criminal Behavior and Mental Health, 19*(3), 193-206. doi: 10.1002/cbm.733

Fazel, S., & Danesh, J. (2002). Serious mental illness in 23,000 prisoners: A systematic review of 62 surveys. *The Lancet, 359*(9306), 545-550. doi:10.1016/S0140-6736(02)09727-1

Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: Prevalence, adverse outcomes, and interventions. *Lancet Psychiatry, 3*(9), 871-881. doi: 10.1016/52215-0366(16)30142-0

Fazel, S., & Seewald, K. (2012). Severe mental illness in 33,588 prisoners worldwide: Systematic review and meta-regression analysis. *British Journal of Psychiatry, 200*(5), 364-373. doi: 10.1192/bjp.bp.111.096370.

Fazel, S., Bains, P., & Doll, H. (2006). Substance abuse and dependence in prisoners: A systematic review. *Addiction, 101*(2), 181-191. doi: 10.1111/j.1360-0443.2006.01316.x

Fennig, S., Craig, T., Lavelle, J., Kovasznay, B., & Bromet, E. J. (1994). Best-estimate versus structured interview-based diagnosis in first-admission psychosis. *Comprehensive Psychiatry, 35*(5), 341-348. doi: 10.1016/0010-440X(94)90273-9

First, M. B., Gibbon, M., Spitzer, R. L., Williams, J. B. W., & Benjamin, L. S. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II).*

Washington, D.C.: American Psychiatric Press, Inc.

First, M. D., Spitzer, R. L., Gibbon, M., & Williams, J. B. (2007). *Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Non-patient Edition (SCID-I/NP).* New York, NY: Biometrics Research, New York State Psychiatric Institute.

Germans, S., Van Heck, G. L., Masthoff, E. D., Trompenaars, F. J., & Hodiamont. P. P. (2010). Diagnostic efficiency among psychiatric outpatients of a self-report version of a subset of screen items of the Structured Clinical Interview for DSM-IV-TR Personality Disorders (SCID-II). *Psychological Assessment*, *22*(4), 945-952. doi: 10.1037/a0021047

Gold, L. H. (2014). DSM-5 and the assessment of functioning: The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0). *Journal of the American Academy of Psychiatry and the Law, 42*(2), 173-181.

Government of Canada (2014). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. Ottawa: ON: Secretariat on Responsible Conduct of Research, Catalogue No: RR4-2/2014E-PDF

Guy, L. S., Poythress, N. G., Douglas, K. S., Skeem, J. L., & Edens, J. F. (2008). Correspondence between self-report and interview-based assessments of antisocial personality disorder. *Psychological Assessment*, *20*(1), 47-54. doi: 10.1037/1040-3590.20.1.47

Hall, R. C. W. (1995). Global Assessment of Functioning: A modified scale. *Psychosomatics*, *36*(3), 267-275. doi: 10.1016/S0033-3182(95)71666-8

Hoge, S. K., Greifinger, R. B., Lundquist, T., & Mellow, J. (2009). Mental health performance measurement in corrections. *International Journal of Offender Therapy and Comparative Criminology*, *53*(6), 634-647. doi: 10.1177/0306624X08322692

Houser, K. A., & Welsh, W. (2014). Examining the association between co-occurring disorders and seriousness of misconduct by female prison inmates. *Criminal Justice and Behavior*, *41*(5), 650-666. doi: 10.1177/0093854814521195

IBM Corporation. (2016). *SPSS statistics 24*. Somers, NY: IBM Corporation Software Group.

Keene, J., & Rodriguez, J. (2005). Mentally disordered offenders: A case linkage study of the criminal justice and mental health populations in the UK. *The Journal of Forensic Psychiatry & Psychology, 16*(1), 167-191. doi: 10.1080/1478994042000325994

Komarovskaya, I., Booker Loper, A., & Warren, J. (2007). Role of impulsivity in antisocial and violent behavior and personality disorders among incarcerated women. *Criminal Justice and Behavior*, *34*(11), 1499-1515. doi: 10.1177/0093854807306354

Lafortune, D. (2010). Prevalence and screening of mental disorders in short-term correctional

facilities. *International Journal of Law and Psychiatry, 33*(2), 94-100. doi: 10.1016/j.ijlp.2009.12.004

Lobbestael, J., Leurgans, M., & Arntz, A. (2011). Inter-rater reliability of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I) and Axis II Disorders (SCID II). *Clinical Psychology and Psychotherapy, 18*(1), 75-79. doi: 0.1002/cpp.693

Lynch, S. M., Dehart, D. D., Belknap, J. E., Green, B. L., Dass-Brailsford, P., Johnson, K. A., & Whalley, E. (2014). A multisite study of the prevalence of serious mental illness, PTSD, and substance use disorders of women in jail. *Psychiatric Services, 65*(5), 670-674. doi: 10.1176/appi.ps.201300172.

Maccio, A., Meloni, F. R., Sisti, D., Rocchi, M. B. L., Petretto, D. R., Masala, C., & Petri, A. (2015). Mental disorder in Italian prisoners: Results of the REDiMe study. *Psychiatry Research, 225*(3), 522-530. doi: 10.1016/j.psychres.2014.11.053

MacDonald, M. (2013). Women prisoners, mental health, violence and abuse. *International Journal of Law and Psychiatry, 36*(3), 293-303. doi: 10.1016/j.ijlp.2013.04.014

Magaletta, P. R., Diamond, P. M., Faust, E., Daggett, D. M., & Camp, S. D. (2009). Estimating the mental illness component of the service need in corrections: Results from the mental health prevalence project. *Criminal Justice and Behavior, 36*(3), 229-244. doi: 10.1177/0093854808330390

Martin, S. G. (2014). Review of the Structured Clinical Interview for DSM-IV Axis II Personality Disorders. *Mental Measurements Yearbook.* retrieved on June 3, 2017 from http://web.a.ebscohost.com.roxy.nipissingu.ca/ehost/detail/detail?vid=4&sid=b434acd8-392248be986a62052ea435dd%40sessionmgr4010&bdata=JnNpdGU9ZWhvc3QtbGl2ZSZzY29wZT1zaXRl#AN=test.2089&db=loh

Mir, J., Kastner, S., Priebe, S., Konrad, N., Ströhle, A., & Mundt, A.P. (2015). Treating substance abuse is not enough: Comorbidities in consecutively admitted female prisoners. *Addictive Behaviors, 46,* 25-30. doi: 10.1016/j.addbeh.2015.02.016 0306-4603

Motiuk, L. L., & Porporino, F. J. (1991). *The prevalence, nature and severity of mental health problems among federal male inmates in Canadian penitentiaries* (Research Report R-24). Ottawa, ON: Correctional Service of Canada.

O'Brien, M., Mortimer, L., Singleton, N., & Meltzer, H. (2003). Psychiatric morbidity among women prisoners in England and Wales. *International Review of Psychiatry, 15,* 153-157. doi: 10.1080/0954026021000046100

Pearson, C., Janz, T., & Ali, J. (2013). Mental and substance use disorders in Canada. *Health at a Glance.* Ottawa, ON: Statistics Canada, Catalogue No>: 82-624-X. Retrieved on July 11, 2017 from http://www.statcan.gc.ca/pub/82-624-x/2013001/article/11855-eng.htm

Power, J., & Beaudette, J. N. (2014*). Self-injurious behaviour in treatment centres: Correlates, trajectories, and descriptive analysis* (Research Report, R-303). Ottawa, ON: Correctional Service of Canada.

Power, J., & Usher, A. (2011a). *Correlates and trajectories to self-injurious behaviour in federally sentenced men* (Research Report, R-250). Ottawa, ON: Correctional Service of Canada.

Power, J., & Usher, A. (2011b). *Correlates and trajectories to self-injurious behaviour in federally sentenced women* (Research Report, R-245). Ottawa, ON: Correctional Service of Canada.

Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K.D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *Journal of Substance Abuse Treatment, 61*, 47-59. doi: 10.1016/j.jsat.2015.09.006 0740-5472

Prins, S. (2014). The prevalence of mental illnesses in U.S. state prisons: A systematic review. *Psychiatric Services, 65*(7), 862-872. doi: 10.1176/appi.ps.201300166

Proctor, S. L., & Hoffmann, N. G. (2012). Identifying patterns of co-occurring substance use disorders in a jail population. *Addiction Research and Theory, 20*(6), 492-503. doi: 103109/16066359.2012.667853

Public Health Agency of Canada (2015). *Report from the Canadian Chronic Disease Surveillance System: Mental Illness in Canada, 2015*. Ottawa, ON: Minister of Health.

Public Safety Canada (2016). *2015 Report: Corrections and Conditional Release Statistical Overview*. Ottawa, ON: Public Works and Government Services Canada, Cat. No.: PS1-3E-PDF

Reingle Gonzalez, J. M., & Connell, N.M. (2014). Mental health of prisoners: identifying barriers to mental health treatment and medication continuity. *American Journal of Public Health, 104*(12), 2328-2333. doi: 10.2105/AJPH.2014.302043

Rezansoff, S. N., Moniruzzaman, A., Gress, C., & Somers, J. M. (2013). Psychiatric diagnoses and multiyear recidivism in a Canadian provincial offender population. *Psychology, Public Policy, and Law, 19*(4), 443-453. doi: 10.1037/a0033907

Roberts, A. D. L., & Coid, J. W. (2010). Personality disorder and offending behaviour: Findings from the national survey of male prisoners in England and Wales. *Journal of Forensic Psychiatry & Psychology, 21*(2), 221–237. doi: 0.1080/14789940903303811

Rothman, K. J., Greenland, S., & Lash, T. L. (2008). *Modern Epidemiology (3 ed.)*. Philadelphia, PA: Lippincott, Williams & Wilkins.

Rush, A. J., First, M. B, Blacker, D. B., Endicott, J., Spitzer, R. L., & Fleiss, J. L. (2008). Global Assessment Scale (GAS); Global Assessment of Functioning (GAF) scale, Social and Occupational Functioning Assessment Scale (SOFAS). In A. J. Rush, M. B. First, & D. B. Blacker (Eds.), *Handbook of Psychiatric Measures (2nd ed.)*. Washington, DC: American Psychiatric Publishing, Inc.

Rush, B., & Koegl, C. J. (2008). Prevalence and profile of people with co-occurring mental and substance use disorders within a comprehensive mental health system. *Canadian Journal of Psychiatry, 53*(12), 810-821. doi: 10.1177/070674370805301207

Ryder, A. G., Costa, Jr., P. T., & Bagby, R. M. (2007). Evaluation of the SCID-II Personality Disorder traits for DSM-IV: Coherence, discrimination, relations with general personality traits, and functional impairment. *Journal of Personality Disorders, 21*(6), 626-637. doi: 10.1521/pedi.2007.21.6.626

Sapers, H. (2014). *Annual Report of the Office of the Correctional Investigator 2014-2015*. Ottawa, ON: Public Safety Canada.

Sarteschi, C. M. (2013). Mentally ill offenders involved with the U.S. criminal justice system: A synthesis. *Sage Open, 3*(3) 1-11. doi: 0.1177/2158244013497029

Schnittker, J., & Bacak, V. (2016). Orange is the new pink: Mental illness, gender roles, and physical victimization in prisons. *Society and Mental health, 6*(1), 21-35. doi: 10.1177/2156869315609733

Senior, J., Birmingham, L., Harty, M. A., Hassan, L., Hayes, A. J., Kendall, K.,...& Shaw, J. (2013). Identification and management of prisoners with severe psychiatric illness by specialist mental health services. *Psychological Medicine, 43*(7), 1511–1520. doi:10.1017/S0033291712002073

Shear, M. K., Green, C., Kang, J., Ludewig, D., Frank, E., Swartz, H. A., & Hanekamp, M. (2000). Diagnosis of nonpsychotic patients in community clinics. *American Journal of Psychiatry, 157*(4), 581-587. doi: 10.1176/appi.ajp.157.4.581

Sirdifield, C., Gojkovic, D., Brooker, C., & Ferriter, M. (2009). A systematic review of research on the epidemiology of mental health disorders in prison populations: A summary of findings. *Journal of Forensic Psychiatry & Psychology, 20*(1), S78-S101. doi: 10.1080/14789940802594445.

Slade, K., & Forrester, A. (2013). Measuring IPDE-SQ personality disorder prevalence in pre-sentence and early-stage prison populations, with sub-type estimates. *International Journal of Law and Psychiatry, 36*(3), 207-212. doi: 10.1016/j.ijlp.2013.04.018

Smink, F. R., van Hoeken, D., Oldehinkel, A. J., & Hoek, H. W. (2014). Prevalence and severity of DSM-5 eating disorders in a community cohort of adolescents. *International Journal of Eating Disorders, 47*(6), 610-619. doi: 10.1002/eat.22316

Smith, G. N., Ehmann, T. S., Flynn, S. W., MacEwan, G. W., Tee, K., Kopala, L. C., ... Honer, W. G. (2011). The assessment of symptom severity and functional impairment with DSM-IV axis V. *Psychiatric Services, 62*(4), 411-417. doi: 10.1176/ps.62.4.pss6204_0411.

Söderberg, P., Tungström, S., & Åke Armelius, B. (2005). Reliability of Global Assessment of Functioning ratings made by clinical psychiatric staff. *Psychiatric Services, 56*(4), 434-438. doi: 10.1176/appi.ps.56.4.434

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among inmates. *Psychiatric Services, 60*(6), 761-765. doi: 10.1176/appi.ps.60.6.761

Steadman, H. J., Robbins, P. C., Islam, T., & Osher, F. C. (2007). Revalidating the Brief Jail Mental Health Screen to increase accuracy for women. *Psychiatric Services, 58*(12), 1598-1601. doi: 10.1176/ps.2007.58.12.1598

Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: A systematic review and meta-analysis 1980-2013. *International Journal of Epidemiology, 43*(2), 476-493. doi: 10.1093/ije/dyu038

Stewart, L. A., Wilton, G., & Cousineau, C. (2012). *Federally Sentenced Offenders with Mental Disorders: Correctional Outcomes and Correctional Response* (Research Report R-268). Ottawa, ON: Correctional Service of Canada.

Støre-Valen, J., Ryum, T., Pedersen, G. A. F., Pripp, A. H., Jose, P. E., & Karterud, S. (2015). Does a web-based feedback training program result in improved reliability in clinicians' ratings of the Global Assessment of Functioning (GAF) scale? *Psychological Assessment, 27*(3), 865-873. doi: 10.1037/pas0000086

Trestman, R. L., Ford, J., Zhang, W., & Wiesbrock, V. (2007). Current and lifetime psychiatric illness among inmates not identified as acutely mentally ill at intake in Connecticut's jails. *Journal of the American Academy of Psychiatry and the Law, 35*(4), 490-500.

Tungström, S., Söderberg, P., & Armelius, B-Å. (2005). Relationship between the global assessment of functioning and other DSM Axes in routine clinical work. *Psychiatric Services, 56*(4), 439-443. doi: 10.1176/appi.ps.56.4.439

Tye, C. S., & Mullen, P. E. (2006). Mental disorders in female prisoners. *Australian and New Zealand Journal of Psychiatry, 40*(3), 266-271. doi: 10.1080/j.1440-1614.2006.01784.x

Ullrich, S., Deasy, D., Smith, J., Johnson, B., Clarke, M., Broughton, N., & Coid, J. (2008).

Detecting personality disorders in the prison population of England and Wales: Comparing case identification using the SCID-II screen and the SCID-II clinical interview. *Journal of Forensic Psychiatry & Psychology, 19*(3), 301-322. doi: 10.1080/14789940802045182

Vatnaland, T., Vatnaland, J., Friis, S., & Opjordsmoen, S. (2007). Are GAF scores reliable in routine clinical use? *Acta Psychiatr Scand, 115*(4), 326–330. doi: 10.1111/j.1600-0447.2006.00925.x

Vicens, E., Tort, V., Duenas, M., Muro, A., Perez-Arnau, F., Arroyo, J.M., … Sarda, P. (2011). The prevalence of mental disorders in Spanish prisons. *Criminal Behaviour and Mental Health, 21*(5), 321-332. doi: 10:1002/cbm.815

Walmsley, R. (2015). *World Female Imprisonment List (3rd ed.)*. London, UK: Institute for Criminal Policy Research, Birkbeck, University of London.

Walter, M., Wiesbeck, G. A., Dittmann, V., & Graf, M. (2011). Criminal recidivism in offenders with personality disorders and substance use disorders over 8 years of time at risk. *Psychiatry Research, 186*(2), 443–445. doi: 10.1016/j.psychres.2010.08.009

Wetterborg, D., Langstrom, N., Andersson, G., & Enebrink, P. (2015). Borderline personality disorder: prevalence and psychiatric comorbidity among male offenders on probation in Sweden. *Comprehensive Psychiatry, 62*, 63–70. doi:10.1016/j.comppsych.2015.06.014

Williams, L., Jacka, F., Pasco, J., Henry, M., Dodd, S., Nicholson, G.,…& Berk, M. (2010). The prevalence of mood and anxiety disorders in Australian women. *Australasian Psychiatry, 18*(3), 250-255. doi: 10.3109/10398561003731155

Wilton, G., & Stewart, L. A. (2012). *Outcomes for offenders with concurrent substance abuse and mental health disorders* (Research Report, R-277). Ottawa, Ontario: Correctional Service of Canada.

WHO (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of the American Medical Association, 291*(21), 2581-2590. doi:10.1001/jama.291.21.2581

Zanarini, M. C., & Frankenburg, F. R. (2001). Attainment and maintenance of reliability of Axis I and Axis II disorders over the course of a longitudinal study. *Comprehensive Psychiatry, 42*(5), 369-374.doi: 10.1053/comp.2001.24556

Zimmerman, M., Ruggero, C. J., Chelminski, I., & Young D. (2010). Psychiatric diagnoses in patients previously overdiagnosed with bipolar disorder. *Journal of Clinical Psychiatry, 71*(1), 26-31. doi: 10.4088/JCP.08m04633

Appendix A

Table A1

Prevalence Rates of Mental Disorders among Federal Women Offenders: In Custody Sample (N = 154)

Disorder	Lifetime % (*n*)	Current % (*n*)
Mood disorders	**61.7 (95)**	**22.1 (34)**
Bi-polar I disorder	9.1 (14)	†
Bi-polar II disorder	†	†
Other bi-polar disorders	†	†
Major depressive disorder	46.8 (72)	9.7 (15)
Dysthymic disorder	9.7 (15)	9.1 (14)
Depressive disorder not otherwise specified	3.9 (6)	†
Mood disorder due to a general medical condition	0	0
Substance-induced mood disorder	3.9 (6)	0
Psychotic disorders[a]	**7.1 (11)**	**4.5 (7)**
Alcohol and substance use disorders	**76.0 (117)**	-
Alcohol abuse or dependence	48.7 (75)	-
Non-alcohol substance abuse or dependence	72.1 (111)	-
Anxiety disorders	**57.1 (88)**	**53.9 (83)**
Panic disorder	18.8 (29)	14.3 (22)
Agoraphobia without history of panic	3.3 (5)	3.3 (5)
Social phobia	10.5 (16)	9.2 (14)
Specific phobia	5.2 (8)	5.2 (8)
Obsessive-compulsive disorder	10.4 (16)	10.4 (16)
Posttraumatic stress disorder	34.4 (53)	33.1 (51)
Generalized anxiety disorder	13.6 (21)	13.0 (20)
Anxiety disorder due to a general medical condition	†	†
Substance-induced anxiety disorder	0	0
Anxiety disorder not otherwise specified	5.9 (9)	5.9 (9)
Eating disorders	**16.2 (25)**	**11.0 (16)**
Anorexia Nervosa	5.8 (9)	†
Bulimia Nervosa	6.5 (10)	5.8 (9)
Binge-eating disorder	3.9 (6)	†
Pathological gambling	**13.6 (21)**	†
Borderline personality disorder (lifetime only)	**33.1 (51)**	-
Antisocial personality disorder (lifetime only)	**49.4 (76)**	-

Note. "(0)" indicates no participant received a rating for that category. Percentages may not add to 100% as participants could meet the diagnostic criteria for more than one disorder. Percentages may vary due to missing data for some diagnoses (i.e. denominators may vary).

[a] – Psychotic disorders included: schizophrenia, schizophreniform, schizoaffective, delusional disorder, brief psychotic disorder, substance abuse or general medical condition causing psychotic symptoms, substance induced psychotic disorder, and psychotic disorder not otherwise specified.

Appendix B

Table B1

Prevalence Rates of Mental Disorder among Indigenous and non-Indigenous Federal Women Offenders: In-Custody Sample N = 154

	Indigenous ($N = 48$)		Non-Indigenous ($N = 106$)	
Disorder	Lifetime	Current	Lifetime	Current
Mood disorders	56.3 (27)	20.8 (10)	64.2 (68)	22.6 (24)
Bi-polar disorders	†	†	13.2 (14)	5.7 (6)
Major depressive disorder	45.8 (22)	12.5 (6)	47.2 (50)	8.5 (9)
Dysthymic disorder	†	†	10.4 (11)	9.4 (10)
Mood Disorders – other	†	†	8.5 (9)	†
Psychotic disorders[c]	10.4 (5)	†	5.7 (6)	†
Alcohol and substance use disorders (lifetime only)	89.6 (43)	-	69.8 (74)	-
Alcohol abuse or dependence	72.9 (35)	-	37.7 (40)	-
Non-alcohol substance abuse or dependence	85.4 (41)	-	66.0 (70)	-
Anxiety disorders	62.5 (30)	60.4 (29)	54.7 (58)	50.9 (54)
Panic disorder	25.0 (12)	22.9 (11)	16.0 (17)	10.4 (11)
Phobias	25.0 (12)	25.0 (12)	16.0 (17)	14.2 (15)
Obsessive-compulsive disorder	10.4 (5)	10.4 (5)	10.4 (11)	10.4 (11)
Posttraumatic stress disorder	41.7 (20)	39.6 (19)	31.1 (33)	30.2 (32)
Generalized anxiety disorder	12.5 (6)	10.4 (5)	14.2 (15)	14.2 (15)
Anxiety Disorders – other	†	†	6.6 (7)	6.6 (7)
Eating disorders	22.9 (11)	18.8 (9)	13.2 (14)	6.6 (7)
Anorexia Nervosa	†	†	5.7 (6)	†
Bulimia Nervosa	14.6 (7)	12.5 (6)	†	†
Binge-eating disorder	†	†	4.7 (5)	†
Pathological gambling	14.6 (7)	0	13.2 (14)	†
Borderline personality disorder (lifetime only)	47.9 (23)	-	26.4 (28)	-
Antisocial personality disorder (lifetime only)	85.4 (41)	-	33.0 (35)	-

†Information suppressed due to frequencies fewer than 5 in one category.

Appendix C

Table C1

GAF Scale Scores by Mental Disorder for Current DSM – IV Axis I and Axis II – BPD and APD Personality Disorder Diagnoses: Federal Women Offenders In-Custody Sample (N = 154)

GAF Score	Axis I[a] Disorders $n = 93$ % (n)	APD only $n = 18$ % (n)	BPD only $n = 3$ % (n)	Axis I[a] & APD or BPD $n = 63$ % (n)
81-90 absent	9.7 (9)	38.9 (7)	0	†
71-80 some mild	22.6 (21)	33.3 (6)	†	17.5 (11)
61-70 some persistent	17.2 (16)	†	†	15.9 (10)
51-60 moderate	11.8 (11)	†	0	14.3 (9)
41-50 some serious	14.0 (13)	†	†	14.3 (9)
31-40 major	16.1 (15)	0	0	22.2 (14)
21-30 inability to function	†	0	0	†
11-20 suffering from neglect	5.4 (5)	0	0	7.9 (5)
1-10 immediate danger	†	0	0	†

Note. GAF = Global Assessment of Functioning. [a] Excluding alcohol and substance use disorders if they are the only Axis I disorders. Of all of the women interviewed with any current mental disorder, 32.8% (30/122) demonstrated at least some serious symptoms or impairment in functioning.
†Information suppressed due to frequencies fewer than 5 in one category.

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UN PEACEKEEPING

Vancouver Canada 2017

Defence Ministerial

REPORT

14-15 November, 2017

United Nations Peacekeeping

un.org/peacekeeping

Canada

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COVER

1. Two Nigerian officers from the UN Formed police unit in Haiti speak with children as they patrol the streets of Port-au-Prince.

2. Prime Minister Justin Trudeau and UN Under-Secretary-General Jean-Pierre Lacroix present the UN Military Gender Advocate of the Year Award to Major Seitebatso Pearl Block.

3. Angelina Jolie, UN High Commission for Refugees Special Envoy and Co-Founder of the Preventing Sexual Violence Initiative, participates in a roundtable with senior military officials.

4. Hon. Harjit Sajjan, Minister of National Defence and H.E. Rt. Hon. Michaëlle Jean, Secretary General of the Organisation internationale de la Francophonie participate in the "Youth as Peacebuilders" workshop.

Further information

Further information about the 2017 Peacekeeping Ministerial may be found at the following address:
https://www.canada.ca/en/department-national-defence/campaigns/peacekeeping-defence-ministerial.html

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UN PEACEKEEPING DEFENCE MINISTERIAL

OBJECTIVES OF THE MINISTERIAL

1. Take stock of the efforts achieved since the last UN Peacekeeping Defence Ministerial, held in London, United Kingdom, in 2016;
2. Encourage new pledges from Member States to close key capability gaps for UN peacekeeping operations;
3. Advance peacekeeping reform to improve the UN's capacity to better plan and perform peacekeeping operations;
4. Foster pragmatic and innovative solutions to make peacekeeping operations more effective, by building on the "3Ps" (pledges, planning, performance) with the addition of a new focus on partnerships.

SUMMARY

On 14-15 November 2017, the United Nations Peacekeeping Defence Ministerial in Vancouver brought together the largest ever gathering of defence delegations dedicated to peacekeeping. Canada, the United Nations and 10 co-host nations – Bangladesh, Ethiopia, Indonesia, Japan, the Netherlands, Pakistan, Rwanda, Uruguay, the United States, and the United Kingdom – welcomed Ministers of Defence as well as official delegations from 80 countries and five international organizations to elicit new pledges and advance existing pledges with the aim of filling gaps in UN capabilities, reforming peacekeeping to address recurring problems, increasing the number of women involved in peacekeeping and modernizing tools by doing peacekeeping differently. The Vancouver Ministerial was the latest in a series of high-level meetings that have focused on marshalling extra support to assist in meeting the world's list of needs in the area of UN peacekeeping.

Hon. Marie-Claude Bibeau, Minister of International Development and la Francophonie; Hon. Harjit Sajjan, Minister of National Defence; Prime Minister Justin Trudeau; Hon. Chrystia Freeland, Minister of Foreign Affairs; and General Jonathan Vance, Chief of the Defence Staff.

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Following a moment of silence for fallen peacekeepers, the plenary event was officially opened by the Honourable Harjit S. Sajjan, Canadian Minister of National Defence. To guide deliberations, Jean-Pierre Lacroix, UN Under-Secretary-General for Peacekeeping Operations, underlined the priorities of modern peacekeeping:

- the importance of prioritizing political solutions;
- the protection of civilians; and
- the need for peacekeepers to be more effective and more mobile, with better training.

Speaking to the assembled delegations, Prime Minister Justin Trudeau celebrated Canada's tradition of peacekeeping, beginning with the legacy of Lester B. Pearson, who won the Nobel Peace Prize in 1957 for his leadership in resolving the Suez Canal Crisis. The Prime Minister emphasized that today's peacekeeping challenges are those of a new era. To this end, Canada announced a number of pledges, including an initiative to increase the number of women in peacekeeping – the Elsie Initiative on Women in Peace Operations. Prime Minister Trudeau also unveiled the Vancouver Principles, a comprehensive set of pledges including political commitments by Member States to enhance the training, planning, and conduct of their own forces as they relate to preventing the recruitment and use of child soldiers.

In recognition of her tireless work advocating equality in peacekeeping and in recognition of the crosscutting importance of gender, Major Seitebatso Pearl Block of the South African National Defence Force received the UN Military Gender Advocate of the Year Award.

During the conference, 49 delegations announced new peacekeeping pledges and 14 delegations advanced pledges that had been made previously. Many of these announcements consisted of 'smart pledges' – an emerging practice to address critical capability gaps and improve coordination with the United Nations and amongst Member States.

THE ROAD TO VANCOUVER

The scope of the 2017 Defence Ministerial extended well beyond the events of 14-15 November in Vancouver. Preparatory meetings in Kigali, Tokyo, and Dhaka were held in the run-up to the Ministerial by co-hosts Rwanda, the Netherlands, Japan and Bangladesh, with each meeting focused on making progress towards a key challenge of modern peacekeeping. These preparatory meetings were attended by 46 Member States and three international organizations, and represented a new approach to the Peacekeeping Ministerial that was welcomed by the United Nations as a direct contribution to the success of the event in Vancouver. In addition, a civil Society Roundtable also was held in October 2017 in Ottawa, providing civil society actors the chance to make concrete recommendations on peacekeeping reform and modernization, which were then relayed to the delegations assembled in Vancouver. These events helped establish networks of peacekeeping expertise, communication, and cooperation that will live on past the conclusion of the Ministerial event in Vancouver.

GENDER AND PEACEKEEPING

Recognizing that integrating gender perspectives and empowering women are integral to improving the effectiveness of UN peacekeeping, these crosscutting issues were integrated into all aspects of the Ministerial, including in discussions on peacekeeping planning and performance. As of October 2017, fewer than 3,000 women military

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peacekeepers were deployed – 3.6% of the total. Implementation of UN Security Council Resolution 1325 has been unacceptably slow, and numerous delegations affirmed their commitment to increasing the number of well-trained, well-equipped women peacekeepers on the ground.

The importance of gender awareness and gender equality was raised consistently throughout the Ministerial, and across panels discussing smart pledges, training and capacity building, protecting those at risk, and early warning and rapid deployment. Of the 49 delegations that made new peacekeeping pledges, 32 of these pledges contained a gender element.

POLICE IN PEACEKEEPING

The number of police personnel deployed in United Nations peacekeeping missions has increased significantly in recent years and police-related tasks in mission mandates have become more complex. UN Police engage across the entire spectrum of peace and security and carry out dynamic mandates encompassing operations, training, mentoring, advising, capacity building and, in some instances, direct law enforcement. In his interventions, Luís Carrilho, the United Nations Police Adviser, reaffirmed the key role of police in the protection of civilians – including protection against gender-based violence – and encouraged troop contributing countries to increase pledges of police capabilities to peacekeeping operations. He noted that police are often the most visible manifestation of the State and an essential element for the promotion of peace, post-conflict reconstruction and sustainable development.

Hon. Raul Jungmann (Brazil), Ms. Jane Connors (UN); Hon. José de Azeredo Lopes, (Portugal)

A number of Member States made new pledges for police personnel and police resources in Vancouver and many noted the requirement for better coordination across uniformed services, including the need for clear rules of engagement for United Nations and local police components. In that context, many Member States said that increasing the number of women in United Nations police – women currently make up less than 10% of police peacekeepers – will also help establish trust with local populations and help create a safe environment for victims of sexual violence to report crimes. The United Nations Under-Secretary-General for Peacekeeping Operations noted that police deployment is becoming an increasingly important tool in complex United Nations peacekeeping operations. Twenty-one countries pledged commitments related to policing in UN peacekeeping, which include pledges of: police officers, including increasing the number of women police officers; Formed Police Units; SWAT-units and Specialized Police Teams.

Mr. Luís Carrilho, United Nations Police Adviser

Mr. Chris Lewis, Councillor for the Squamish Nation and Ms. Charlene Aleck, Councillor for the Isleil Waututh Nation

Prime Minister Justin Trudeau

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OPERATING IN FRANCOPHONE ENVIRONMENTS

Today, some of the United Nations most complex peacekeeping operations take place in francophone environments and past experience demonstrates the central role of linguistic capabilities in building dialogue with communities. As one delegation noted, the focus on the operations in francophone environments in the context of United Nations peacekeeping is not primarily about promoting the use of French, but rather about increasing effectiveness. Simply put, given the number of United Nations peacekeeping operations in francophone countries, the growing complexity of peacekeeping mandates and increasing interactions with the local population, there is a growing need for peacekeepers to be able to interact with local populations in French.

Michaëlle Jean, the Secretary-General of the *Organisation internationale de la Francophonie*, highlighted in her address the need for personnel deployed on UN peacekeeping operations in francophone environments to be cognizant of the cultural and historical realities they are being deployed to, and to be able to communicate in French with local populations. To that end, eleven Member States pledged to provide capabilities to improve operations in francophone environments, such as additional French-speaking troops, additional training in French and translations into French of resources available to UN personnel. Beyond individual pledges, some delegations recognized the need for bilateral and multilateral partnerships between francophone countries and international organizations, such as the *Organisation internationale de la Francophonie*, and non-French-speaking troop contributing countries.

H.E. Rt. Hon. Michaëlle Jean, Secretary-General of the Organisation internationale de la Francophonie and recording artist, peace activist, and former child soldier, Emmanuel Jal.

Keynote Address

Angelina Jolie, UN High Commission for Refugees (UNHCR) Special Envoy and Co-Founder of the Preventing Sexual Violence Initiative

In her keynote address, the UNHCR Special Envoy implored participants to end gender-based violence and argued that tackling its most extreme form, sexual violence as a weapon of war, is vital for future peace and security:

"Even if we accept that sexual violence has nothing to do with sex, that it is a crime, and that it is used as a weapon, many people still believe that it is simply not possible to do anything about it. Look at how hard it is in our own societies, the argument goes. How could we possibly prevent sexual violence in the extreme conditions of war? It is hard, but it is not impossible. We have the laws, the institutions, and the expertise in gathering evidence. We are able to identify perpetrators and those responsible. What is missing is the political will."

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LGen (ret'd.) the Hon. Roméo Dallaire speaks to media.

THE VANCOUVER PRINCIPLES

The Vancouver Principles on Peacekeeping and the Prevention of the Recruitment and Use of Child Soldiers, endorsed by over 50 UN Member States at the time of launch in Vancouver, is an initiative developed by the Canadian government in partnership with the Roméo Dallaire Child Soldiers Initiative that will place greater emphasis in peacekeeping contexts on efforts to prevent the recruitment and use of child soldiers.

Atul Khare, UN Under-Secretary-General for Field Support

"Partnerships with Member States and regional organizations are critical for the success of the United Nations and for the success of peacekeeping. We have partnerships that involve Member States who give us the mandates, who provide us with the troops, who provide us with the financial resources, critical equipment and political support."

The Principles are a set of 17 pledges that build on an existing body of policy and international law surrounding children and armed conflict, including the Paris Principles. The Vancouver Principles focus on the challenges posed by child soldiers in a peacekeeping context, placing additional emphasis on efforts to prevent the recruitment of child soldiers, including through early warning and reporting on grave violations of children's rights.

SMART PLEDGES

Chair: Rt. Hon. Earl Howe, P.C., Minister of State for Defence and Deputy Leader of the House of Lords, United Kingdom

Panelists:

Hon. Frank Bakke-Jensen, Minister of Defence, Norway

MGen (ret'd) Tarique Ahmed Siddique, Defence and Security Advisor to the PM, Bangladesh

Mr. Wim Geerts, Deputy Minister of Defence, Netherlands

Smart pledges are pledges made in conjunction with other Member States and international organizations that fill key capabilities gaps for UN peacekeeping. The Ministerial highlighted smart pledges as a crucial tool to ensure the deployment of key enablers and specialized capabilities. In a panel announcing new and advanced smart pledges by Member States, commitments were made to use new mechanisms to fill the UN's need for rapid deployment, to provide female engagement teams and mixed-gender units to address crucial gaps, to establish medical facilities, and to provide innovations in training.

Panelists also discussed the importance of partnerships between multiple Member States, especially for smaller troop contributing countries. Smart partnerships have been used to provide rotational arrangements between countries, allowing for scarce, high-end capabilities to be deployed on a consistent, longer-term basis. While these partnerships have so far focused on air capabilities, a general interest in extending rotational arrangements to other areas of peacekeeping, such as medical facilities, was expressed. Regional cooperation through smart pledges was specifically highlighted as a way for Member States to work together to ensure that pledges could be targeted to fit the needs of modern peacekeeping operations.

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INNOVATION IN TRAINING AND CAPACITY BUILDING

Chair: Hon. Chrystia Freeland, P.C., M.P., Minister of Foreign Affairs, Canada

Panelists:

Hon. Tomohiro Yamamoto, State Minister of Defence, Japan

Hon. Peter Hultqvist, Minister of Defence, Sweden

Mr. Philippe Errera, Director General International Relations & Strategy, Ministry of Defence, France

Dr. Patricia Flor, Federal Government Commissioner for Disarmament and Arms Control and Director-General for International Order, the United Nations and Arms Control, Germany

MGen Jean-Paul Deconinck, Force Commander MINUSMA

Patrick M. Shanahan, United States Deputy Secretary of Defense

"The world needs strong leadership right now. We come from different backgrounds, experiences and places that influence how we view security challenges, but we have a common goal – to protect and save innocent lives."

A key lesson of peacekeeping missions is the importance of training and capacity building, both in terms of improving the capabilities of peacekeeping forces and in building the strength of the local forces, a vital factor for long-term stability. Contributions by delegations focused on ways to support the professional military skills needed to fulfill peacekeeping mandates and help foster sustainable peace.

Delegations highlighted the importance of UN training standards and evaluation criteria to ensure consistency and effectiveness in the preparation of peacekeepers for deployment. Regional capacity building arrangements and bilateral partnerships, the deployment of mobile training teams and the development of specialized skills such as language skills were raised as key ways to address the challenges facing the UN today. Further, the importance of additional training opportunities for women to increase the number of women peacekeepers, as well as gender-based training programs for all peacekeepers, and not just for women, was stressed.

PROTECTING THOSE AT RISK

Chair: Mr. Jean-Pierre Lacroix, United Nations Under-Secretary-General for Peacekeeping Operations

Panelists:

Mrs. Rebecca Skinner, Associate Secretary of Defence, Australia

Hon. Raul Jungmann, Minister of Defence, Brazil

Hon. José Alberto de Azeredo Lopes, Minister of National Defense, Portugal

Gen James Kabarebe, Minister of Defence, Rwanda

Ms. Jane Connors, Assistant Secretary-General, Victims' Rights Advocate, United Nations

Protecting vulnerable populations is a primary goal of peacekeeping operations and more than 95% of UN peacekeeping personnel currently serve in missions with a mandate to protect civilians. Discussions at the Ministerial highlighted the modern challenges of peacekeeping, with many delegates noting their support for the reforms proposed by United Nations Secretary-General Guterres. In addition to numerous pledges for new resources and capabilities, delegates in Vancouver noted that protecting those at risk requires peacekeeping operations to better anticipate threats to populations. Increasing the number of women in peacekeeping missions was noted by many as an important step to help gain the trust of local communities and protect populations most at risk, including women and children.

Discussions highlighted that protecting those at risk also means holding peacekeepers accountable and bringing those guilty of crimes to justice. In that context all

A Ghanaian police officer of the African Union-United Nations Hybrid Operation in Darfur (UNAMID) poses with school children at the El Sereif camp for internally displaced persons, in South Darfur.

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participating countries pledged their support for the UN Secretary-General's focus on zero tolerance for sexual exploitation and abuse. It was agreed that the protection of civilians is primarily the responsibility of host countries; the United Nations and troop contributing countries must work to create the conditions for this transition to take place.

EARLY WARNING AND RAPID DEPLOYMENT

Chair: Mr. Atul Khare, Under-Secretary-General for Field Support, United Nations

Panelists:

Hon. Khurram Dastgir Khan, Minister of Defence, Pakistan

MGen Shao Yuanming, Deputy Chief of Staff, Joint Staff Department of the Central Military Commission, China

MGen Ben Francis Okello, Chief, Plans and Operations Unit, Peace Support Operations Division in the Peace and Security Department, African Union

Hon. Jüri Luik, Minister of Defence, Estonia, Representing the Presidency of the European Union

Mr. Luis Carrilho, Police Adviser, United Nations

Discussions at the Ministerial highlighted that early warning and rapid deployment mechanisms are needed more than ever to prevent escalations of violence. Noting that the capacity to react to early warnings can build trust with local populations and save lives, a number of participating countries made concrete pledges for units and resources to be made available to the United Nations for rapid deployment. In view of the increasing complexity of peacekeeping operations, various delegations suggested that the United Nations is not only in need of additional resources

Opening Ceremony

but also of new strategies and better coordination mechanisms to avoid overlapping efforts. This includes better coordination between and among troop contributing countries, as well as earlier and more effective engagement with host countries to facilitate quicker deployments.

Some delegations noted a possible role for regional organizations to act in times of crises and fill in gaps in situations where the UN lacks the ability to deploy resources quickly. In addition to their pledges, several Member States reiterated their commitment to UN initiatives including to increase the number and percentage of women deployed on peacekeeping operations and to uphold the highest standards of behaviour as framed in codes of conduct, including the UN Secretary-General's policy of zero tolerance on sexual exploitation and abuse.

Minister of National Defence Harjit Sajjan; UN Under-Secretary-General Jean-Pierre Lacroix and UN Under-Secretary-General Atul Khare

MGen Shao Yuanming (China), MGen Ben Francis Okello (African Union) and Hon. Jüri Luik (European Union)

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Minister of National Defence Harjit S. Sajjan

"It has been an honour and a privilege to host these deliberations. Now, as we return home, we must turn the solemn promise of today into the concrete results of tomorrow.

We must continue to work together to ensure the UN is able to respond to the evolving challenges we face.

Because, as Lester B. Pearson put it so well:

'Of all our dreams today there is none more important – or so hard to realize – than that of peace in the world. May we never lose our faith in it, or our resolve to do everything that can be done to convert it one day into reality.'"

YOUTH AS PEACEBUILDERS WORKSHOP AND TOWN HALL

Involving youth in the promotion of peace and security was a key goal of the UN Peacekeeping Defence Ministerial. Prior to the Ministerial plenary, the United Nations Association in Canada (UNAC) organized a working session and town hall of youth delegates. The delegates discussed a number of recommendations for supporting the role of youth as peacebuilders – including lowering the voting age in Canada, promoting education at all levels, and supporting the role of Indigenous youth – which were then presented to the Minister of International Development and La Francophonie, Marie-Claude Bibeau, Roméo Dallaire, Lieutenant General (ret'd) and head of the Child Soldiers Initiative, and Michaëlle Jean, Secretary-General of the *Organisation internationale de la Francophonie*, participated in the workshop, working with youth delegates to foster innovative ideas. A full account of the event and of recommendations made by youth delegates will be released by UNAC later this year.

Minister of International Development and La Francophonie Marie-Claude Bibeau participates in the "Youth as Peacebuilders" Town Hall.

THE ROLE OF THE PRIVATE SECTOR IN CONFLICT PREVENTION

Coordinated by the Department of National Defence and the office of Dominic Barton, Global Managing Partner at McKinsey & Co, this event brought together the Canadian Minister of National Defence, Harjit S. Sajjan; the Minister of International Development, Marie-Claude Bibeau; and five panelists – John Thornton, Alexandra Guáqueta-Girvin, Charles Sirois, Karin Finkelston, and Ambassador Marc-André Blanchard – to discuss the role of the private sector in conflict prevention. Noting that most conflicts cannot be resolved militarily, panelists discussed the role of the private sector in conflict prevention, economic growth, youth employment and preventing radicalization in conflict areas. They agreed that post conflict reconstruction and the maintenance of peace requires private sector investment and that governments have a role to play in promoting local entrepreneurship – especially for women entrepreneurs.

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Governments must enact regulations to encourage new investments in conflict and remote areas, drawing on the expertise of international organizations such as the International Finance Corporation. As global official development assistance will continue to fall short of the needs of the developing world, participants agreed that there is a compelling case for continuing to invest in innovative ways to address conflict prevention, as research shows this has a significant and lasting impact. As Minister Sajjan noted, the military can 'buy time' to prevent and stop conflicts, but only a strong civil society and private sector can build sustainable growth.

WOMEN, PEACE, AND SECURITY CHIEFS OF DEFENCE NETWORK

The launch of the Women, Peace and Security Chiefs of Defence Network (WPS CHOD Network) marked the debut of a forum for senior military leaders to advance the Women, Peace and Security agenda in national militaries by sharing best practices, addressing barriers and challenges, and measuring progress. The event was co-hosted by Bangladesh, Canada, and the UK with close to 30 countries and 65 representatives attending. Remarks from co-hosts focused on the importance of actively engaging CHODs as those in positions of influence on WPS and the integral role of gender perspectives in operational planning and decision making. Bangladesh, Canada and the UK announced their pledges to the network, followed by interventions from countries pledging to join the network in addition to pledges related to advancing the tenets of UNSCR 1325 and the WPS agenda in their national armed forces. The Network agreed to meet on the margins of conferences like the UN Peacekeeping Defence Ministerial to evaluate progress on pledges and to discuss challenges.

Ms. Jody Thomas, Deputy Minister of National Defence; Hon. Harjit Sajjan, Minister of National Defence; Prime Minister Justin Trudeau and General Jonathan Vance, Chief of the Defence Staff.

Delegates from 80 countries and 5 international organizations attended the UN Peacekeeping Defence Ministerial in Vancouver.

Dominic Barton, John Thornton, Alexandra Guáqueta-Girvin, Charles Sirois, Karin Finkelston and Ambassador Marc-André Blanchard participate in the panel discussion on the role of the private sector in conflict prevention.

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ANNEX A
LIST OF PARTICIPANTS

African Union Commission
Argentina*
Armenia*
Australia*
Austria*
Bangladesh*
Belgium*
Benin*
Bhutan*
Brazil
Cambodia*
Cameroon*
Canada*
Chad
Chile*
China*
Colombia*
Côte d'Ivoire
Croatia*
Czech Republic*
Denmark
Egypt*
Estonia
Ethiopia*
European Union*
Fiji*
Finland*
France*
Gambia*
Georgia
Germany*
Ghana*
Greece
Guatemala
Hungary
India*
Indonesia*
Ireland*
Italy*
Japan*
Jordan*
Kazakhstan*
Kenya*
Kyrgyzstan
Lithuania*
Malaysia
Mexico*
Mongolia*
Morocco*
NATO*
Nepal*
Netherlands*
New Zealand
Nigeria*
Norway*
Organisation internationale de la Francophonie
Pakistan*
Peru*
Philippines*
Poland*
Portugal*
Republic of Korea*
Romania*
Russian Federation
Rwanda*
Senegal*
Serbia
Sierra Leone
South Africa
Spain
Sri Lanka*
Sweden*
Thailand*
Tunisia
Turkey*
Uganda*
Ukraine*
United Arab Emirates
United Kingdom of Great Britain and Northern Ireland*
United Nations
United Republic of Tanzania*
United States of America*
Uruguay*
Vietnam*
Zambia*

*indicates new and/or advanced pledge announcements in Vancouver

For more detailed information on specific pledges by delegation, please visit:
https://www.canada.ca/en/department-national-defence/campaigns/peacekeeping-defence-ministerial/pledges.html

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ANNEX B
2017 UN PEACEKEEPING DEFENCE MINISTERIAL: VANCOUVER COMMUNIQUÉ

From 14-15 November 2017, delegations from 80 countries met in Vancouver, Canada, to re-affirm their commitment to United Nations peacekeeping.

For over sixty years, UN peacekeeping has served as the standard bearer of the world's shared commitment to international peace and security, proving to be one of the most effective tools available to assist host countries and their populations, in navigating the difficult path from conflict to peace.

We salute the brave women and men who serve in peacekeeping operations around the world, and pay tribute to those who have made the ultimate sacrifice in the pursuit of peace.

As these operations grow in complexity, the UN too must evolve; not just to keep pace, but to anticipate, to adapt, and to respond – differently and better – to the challenges before us. As Members of the United Nations, whether as host nations or as troop, police, financial, or equipment contributors, we have an essential role in this evolution. We recognise that ours can only be a shared success, achieved in partnership with the UN Secretariat, regional organisations, and with each other.

MOVING FORWARD IN UN PEACEKEEPING: WORKING DIFFERENTLY AND BETTER, TOGETHER

To this end, we must work together to reform our shared institutions, enhance operational effectiveness, and to make a sustained and collective effort to address capability gaps in UN peacekeeping. It also requires us to integrate gender perspectives in defining and delivering these capabilities, if we are to truly do things differently and better.

We are therefore encouraged by the Secretary-General's efforts to pursue comprehensive reform in the areas of management, development, peace and security, and gender. We take note of the 2015 Peace Operations Review[1], and the complementary focus of these processes in orienting UN peacekeeping towards a greater field-focus, and in placing people at the centre of our efforts. The UN must evolve to better address critical challenges in the design, planning, resourcing, execution and oversight of peacekeeping operations.

We welcome the new pledges made by 49 delegations at the Vancouver Ministerial, and the progress these pledging conferences have achieved in meeting persistent capability gaps and improving the performance and capabilities of uniformed and civilian personnel. As a result of collective efforts— planning, pledges, performance, together with the primacy of politics and partnerships — have come to underpin our approach to strategic force generation and are integral to the success of UN peacekeeping.

1. The report of the High-level Independent Panel on Peace Operations (A/70/95-S/2015/446) and the report of the Secretary-General on the implementation of the Panel's recommendations (A/70/357-S/2015/682)

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As we continue to improve strategic force generation, we must broaden our planning horizons, moving beyond short-term operational gaps or troop and police ceilings as drivers for capability discussions; systematically and transparently build longer-term solutions for force generation, including through better data-driven mission analytics; and proactively address gender, police and francophone capacities, which remain in short supply and are important to the success of UN peacekeeping. We should also consider, from the start, exit strategies for peacekeeping operations.

In line with these objectives, in Vancouver, we identified concrete ways to move forward in UN peacekeeping, working differently and better, together, by:

- Re-affirming our commitment to UN peacekeeping, through the next generation of *smart* pledges;
- Improving our ability to deliver on this commitment, through innovations in training and capacity-building;
- Aligning our corresponding capabilities to where they are most needed in the field, through concerted and integrated strategies in order to protect those most at risk, and
- Enhancing the effectiveness of how we deliver these capabilities, through improved approaches to partnering and planning in early warning and rapid deployment.

We further affirmed that integrating gender perspectives, increased knowledge of local language and culture, including the continuing need to focus on operating in francophone environments, and strengthening UN Police are key to the long-term success of these objectives.

SMART PLEDGES

First and foremost, we affirmed the necessity of moving beyond traditional models of pledging and deploying to consider ways that multiple countries could share the burden of providing the capabilities that are in highest demand. *Smart* pledges serve as an enabler in their own right and provide the predictability of supply that is needed to enhance a mission's chance of long-term success. We encourage Member States to identify where they can jointly implement *smart* pledges and commend initiatives underway, such as efforts amongst Member States and the UN Secretariat to establish rotation plans for military transport aircraft in the UN Multidimensional Integrated Stabilisation Mission in Mali.

From the very beginning, strategic force generation pushes us to consider the capabilities that are needed to fulfil mandates and ensure the safety and security of United Nations personnel in the field. *Smart* pledges are a means of meeting the most critical capability gaps in UN peacekeeping, particularly in areas such as aviation, engineering, and medical.

In this regard, we encourage the UN Secretariat to work closely with Member States, and particularly troop, police,

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financial and equipment contributing countries, to strengthen the capabilities of UN peacekeeping missions. We reiterate our call for the Secretary-General to ensure that the UN – in particular those offices overseeing peacekeeping, field support and management – has the systems in place to deploy, absorb and sustain newly pledged assets rapidly and in accordance with the specific needs of individual missions, including in areas as airlift, rapid engineering support, force headquarters and police and civilian recruitment.

Effective mandate implementation also requires sustained focus on addressing chronic gaps in relation to policing, francophone and gender capacities. These capacities are critical to mission objectives, maintaining meaningful dialogue with local populations, as well as helping to build the foundation for host nation success.

We further recognise that greater women's participation in peacekeeping is directly linked to improved operational effectiveness. Women's participation broadens the skills and capacities among all categories of personnel and improves the mission's image, accessibility, and credibility vis-à-vis the local population. We therefore call on Member States to realise commitments made at the London UN Peacekeeping Ministerial Conference to double the number of female peacekeepers in missions by 2020, including deploying, at minimum, 15% (military staff officers and observers) and 20% (police) female personnel. We welcome the launch of the Women, Peace and Security Chiefs of Defence Network, which will contribute to these goals, and encourage Member States to appoint Champions and join the network.

We acknowledge that in order to address structural barriers preventing the full involvement of women in national militaries and UN peacekeeping, these objectives should be backed by targeted female recruitment, training, and promotion initiatives; retention strategies; reviews of restrictions on military occupations; regular reporting on the proportion of female and male participation; and implementation of gender-responsive budgeting tools. We further note the importance of empowering women peacekeepers in order to ensure their equal access to relevant senior leadership positions.

INNOVATION IN TRAINING AND CAPACITY BUILDING

Second, we called for a renewed global training partnership for UN peacekeeping and we encouraged Member State pledges for peacekeeping capacity-building. The complexities of today's operations require coordinated and cross-cutting action to enhance the equipping and training of peacekeepers, including UN police. Notwithstanding that troop and police contributing countries remain responsible for the delivery of training, Member States, regional organisations, and the UN Secretariat bring a collective wealth of knowledge and experience that is unparalleled to that of any single effort.

Thus, we encourage this renewed relationship to be built on sustainable training and capacity building and peer-to-peer learning, supported by expanded triangular partnerships between donors, troop and police contributing countries and the UN Secretariat. This would include frameworks driven by long-term force and police generation needs, informed by data-driven performance assessments, and ensuring continuity between peacekeepers receiving equipment and training and those being deployed.

We welcome the development of the train-the-trainer centre in Entebbe and encourage greater innovative practices such as the use of mobile training teams. Similarly, in recognising the value of training and support for mission leadership, we further welcome the move towards in-mission scenario-based training and leadership partnering initiatives.

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We acknowledge the need to strengthen pre-deployment training for UN police, including through the use of the Strategic Guidance Framework as the basis for operational guidance and training tools to ensure coherence across all police-contributing countries.

We recognise the existence of barriers to the development and deployment of qualified women peacekeepers and peacekeeping instructors, and commit to creating mechanisms to overcome these obstacles, in order to provide greater opportunities for women in peacekeeping.

We further acknowledge that a number of large-scale UN peacekeeping operations are taking place in francophone environments. We must continue to address linguistic gaps and enhance operational capabilities in all missions, including those in francophone areas, by leveraging innovative partnership opportunities. We therefore welcome the Ministerial Conference on Peacekeeping in the Francophone Area convened in Paris (October 2016), appreciate the support of the *Organisation internationale de la Francophonie*, and encourage follow-on initiatives to build the capacity of francophone partners to deploy in UN peacekeeping missions.

We also encourage continued efforts to evaluate and improve contingent performance. We agree that high performing peacekeepers are critical to mission success. We strongly emphasise the role of Member States in ensuring operational readiness and certification of their peacekeepers. We recognise the need for the UN to engage earlier and more consistently with troop and police contributing countries in order to identify training gaps and remediation mechanisms to address these gaps where possible

PROTECTING THOSE AT RISK

Third, we underlined that protecting those at risk lies at the heart of modern-day multi-dimensional UN peacekeeping operations. For two decades, the international community has turned to the UN and regional peace operations to respond to conflicts marked by egregious violence toward civilian populations. Today, more than 95% of UN peacekeeping personnel serve in missions with a protection of civilians mandate.

To this end, we emphasise the importance of supporting comprehensive protection of civilians' strategies. This includes training deployed peacekeepers on the protection of civilians and strengthening accountability for the implementation of protection of civilian mandates. We note initiatives by Member States to implement best practices as set out in the Kigali Principles for missions with a protection of civilians mandate.

We note that integrating gender perspectives at all levels of peacekeeping is essential for the protection of civilians. Personnel must be adequately trained to prevent, recognise, and respond to incidents of conflict related sexual violence and gender-based violence. This requires recognition of the unique vulnerabilities faced by women, men, girls and boys, in the peacekeeping setting. Gender considerations must be integrated into all military doctrine and planning, women peacekeepers deployed to engage with certain segments of the local population, and victims'

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rights advocates and protection officers appointed, where appropriate.

We recognise that an equally important component to protecting those at risk includes building the capacity of host states. Where mandated, UN Police play an important role in building the confidence and capacity of the host nation to develop its police and justice services, allowing the UN to reduce and eventually withdraw its peacekeeping operations. Thus, we call on UN Police to put greater focus on fielding and supporting specialised teams that can better support host-state driven needs, as appropriate, and for UN Police to integrate specialised teams into the full range of peacekeeping operations in line with mission mandates.

Moreover, we condemn in the strongest terms sexual exploitation and abuse committed by UN peacekeepers and staff, and call on Member States and the UN Secretariat to redouble efforts on prevention, accountability, and victim assistance. We appreciate the Secretary-General's latest efforts to establish a high-level Circle of Leadership and to develop voluntary compacts with Member States on the elimination of Sexual Exploitation and Abuse, which we encourage all Members to pursue with the UN and implement fully.

We welcome the UN's recent adoption of a victim-centered approach, including the appointment of the Victim's Advocate, and in this regard, will strive to clearly identify policies and adequate standards to assist the victims of such heinous acts.

We also recall that peacekeeping can play an important role with respect to the protection of children in conflict. We note the initiative by Member States to develop standards in this area, including the Vancouver Principles on Peacekeeping and the Prevention of the Recruitment and Use of Child Soldiers.

We further recognise the importance of deploying peacekeeping missions that contribute positively and operate at minimum risk to people, societies and ecosystems, and achieve maximum efficiency in their use of natural resources, wherever possible.

EARLY WARNING AND RAPID DEPLOYMENT

Fourth, we reiterated that effective early warning and rapid deployment are essential to building confidence amongst civilian populations, and to preventing and interrupting escalations of violence.

Fragmentation across the United Nations remains a major impediment for early and effective engagement in peace and security challenges. We urge the UN Secretariat to bring greater coherency across the UN system and to operate as one, to help strengthen early warning, assessment, analysis and situational awareness, including peacekeeping intelligence capacities.

We further encourage the Secretariat to place greater focus on integrated approaches, including planning mechanisms, to support contingency crisis planning. We emphasise that policing is an component of UN peacekeeping where mandated, and we therefore underline the critical importance of fully integrating police planning into the overall mission planning process.

Cooperation and partnership amongst the host state, Security Council Members, troop, police, financial and equipment contributing countries, regional organisations, and the UN Secretariat, are fundamental to leveraging these key pledges, as well as to identifying and removing bureaucratic obstacles that continue to impede rapid deployment to and within the field. The development of a roster of military and police units available to deploy from

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their home country within 60 days is an important step forward.

We continue to acknowledge the critical role played by regional and sub-regional organisations in confronting some of the world's most difficult peace and security challenges. In particular, we recognise the efforts being made by the African Union and its sub regional mechanisms to operationalise the Rapid Deployment Capability of the African Standby Force. We appreciate the potential for innovative practices and partnerships to further develop the Force's operational capability and to enhance the planning capacities of both the AU and the UN.

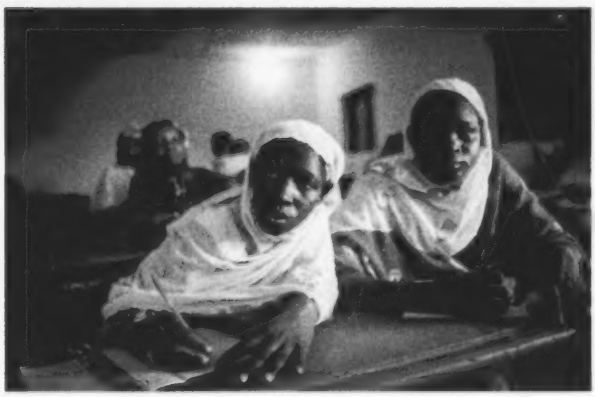
Finally, we note that UN peacekeeping must be ready to respond to a vast array of challenges and that no advantage should be withheld for those working for peace. We therefore encourage the UN to pursue the trial and use of innovative and modern technology in the field, as appropriate and consistent with the basic principles of peacekeeping.

Taken together, and in working differently and better, these efforts will improve UN peacekeeping: building on the strength of our partnerships and common purpose to ensure that UN peacekeeping is fit for purpose in the 21st century.

We recognise this common purpose as the driving force behind our successful discussions at the 2017 UN Peacekeeping Defence Ministerial. We appreciate the support of Member States, regional organisations, and the UN Secretariat in the lead up to the Vancouver Ministerial, including the three preparatory conferences convened in Bangladesh, Japan and Rwanda. We further appreciate the steadfast support of the co-hosts of the Vancouver Ministerial, including Bangladesh, Ethiopia, Indonesia, Japan, Netherlands, Pakistan, Rwanda, United Kingdom, United States and Uruguay.

Lastly, we commend the efforts of Member States in advancing their pledges since 2014, and we encourage all Member States to ensure that their pledges are registered in the Peacekeeping Capability Readiness System. We note that pledges made at these high level conferences are making a difference on the ground, saving lives, and improving UN peacekeeping.

The Vancouver Communiqué has been endorsed by the following Member States: Argentina, Armenia, Australia, Austria, Bangladesh, Belgium, Benin, Bhutan, Brazil, Cambodia, Cameroon, Canada, Chile, China, Colombia, Croatia, Czech Republic, Denmark, Estonia, Ethiopia, Fiji, Finland, France, Gambia, Germany, Ghana, Greece, Guatemala, Hungary, Ireland, Italy, Japan, Kazakhstan, Kenya, Kyrgyzstan, Lithuania, Malaysia, Mexico , Morocco, Nepal, Netherlands, New Zealand, Nigeria, Norway, Pakistan, Peru, Philippines, Poland, Portugal, Republic of Korea, Romania, Rwanda, Senegal, Serbia, Sierra Leone, South Africa, Spain, Sri Lanka, Sweden, Thailand, Uganda, Ukraine, United Republic of Tanzania , United States, United Kingdom, Vietnam, and Zambia.



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ANNEX C
VANCOUVER PRINCIPLES ON PEACEKEEPING AND THE PREVENTION OF THE RECRUITMENT AND USE OF CHILD SOLDIERS

The Vancouver Principles are a set of political commitments made by member states regarding training, planning, and the conduct and care of their own forces. Moreover, the Vancouver Principles take an assertive stance on preventing child recruitment in the context of peacekeeping operations, specifically with regard to early warning and the active prevention of recruitment.

The Vancouver Principles were launched on the margins of the UN Peacekeeping Defence Ministerial conference on November 15, 2017.

The Vancouver Principles are as follows:

We, the Member States endorsing the Vancouver Principles on Peacekeeping and the Prevention of the Recruitment and Use of Child Soldiers,

Deeply concerned by the widespread recruitment and use of children in situations of armed conflict by armed forces and armed groups, including as fighters, cooks, porters, messengers, spies, or for sexual purposes, as well as other Grave Violations against children in situations of armed conflict,

Reiterating our strong commitment to the protection of children affected by armed conflict and to ending and preventing Grave Violations against children,

Recognizing that the recruitment and use of children are prevalent in areas of contemporary peacekeeping operations, and recalling that peacekeeping can play a role in preventing Grave Violations against children in armed conflict,

Recognizing the important steps taken by the United Nations, Member States, civil society, and other relevant actors to address the recruitment and use of child soldiers,

Recalling United Nations Security Council resolutions 1261 (1999), 1314 (2000), 1379 (2001), 1460 (2013), 1539 (2004), 1612 (2005), 1882 (2009), 1998 (2011), 2068 (2012), 2143 (2014), and 2225 (2015),

Building upon the success of the Paris Principles on their 10th anniversary and seeking to further articulate their guidance to the peacekeeping context,

Emphasizing the need to prioritize and operationalize the prevention of the recruitment and use of child soldiers in areas of operation of peacekeeping, noting the critical role of such prevention to the achievement of peace and security, and taking into account the differential impact of conflict on girls and boys,

Hereby pledge:

MANDATES

1. To strongly encourage the inclusion of appropriate child protection provisions, including the prevention of recruitment and use of child soldiers, in all United Nations peacekeeping mandates, including for regional peacekeeping operations.

PLANNING

2. To prioritize the prevention of the recruitment and use of child soldiers in the strategic and operational planning of all peacekeeping operations.

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EARLY WARNING

3. To support United Nations efforts to monitor, report, identify, and address early warning signs of the recruitment and use of child soldiers, recognizing that such acts can amount to war crimes and can be a precursor of other war crimes, including attacks on civilians and civilian objects, crimes against humanity, and genocide.

CHILD PROTECTION FOCAL POINTS

4. To appoint child protection focal points throughout our mission command structures, both military and police, to support the development of a common international standard endorsed by participating nations and the United Nations for training and certification of such focal points, and to enable and encourage active communication, coordination, and cooperation between such focal points and civilian Child Protection Advisors as well as other child protection actors.

TRAINING

5. To ensure that all our peacekeepers receive training on child protection prior to their deployment to peacekeeping operations and to integrate the prevention of the recruitment and use of child soldiers, as well as clear guidance regarding interactions with children associated with armed forces or armed groups, within our peacekeepers' training, education, and doctrine to a common agreed international standard endorsed by the United Nations, and to undertake regular reviews of such training and doctrine to ensure its effectiveness.

MONITORING AND REPORTING

6. To take steps to ensure our peacekeepers report incidents of Grave Violations against children in situations of armed conflict, including the recruitment and use of children, to United Nations Child Protection Advisers or through the appropriate channels established in peacekeeping operations, and to include such monitoring and accountability measures within our national mission mandate and peacekeeping training.

PROTECTION AND CARE OF CHILDREN

7. To take proactive measures to ensure that all children, including those associated with armed forces and armed groups, who come into contact with our peacekeepers during peacekeeping operations are treated in accordance with international humanitarian law and applicable international human rights law, with special consideration of their status as children, and are protected against violations of international humanitarian law and applicable international human rights law, and that any requirements for the care and aid of such children are appropriately addressed and communicated to Heads of Missions and the military chain of command in the most expeditious manner possible in the circumstances.

PREVENTION

8. To act effectively in response to credible information, and where authorized by the mission mandate and our rules of engagement, to protect children at risk of recruitment or use as child soldiers and other Grave Violations.

DETENTION

9. To ensure that all children apprehended and/or temporarily detained in accordance with mission-specific military rules of engagement are treated in a manner consistent with international norms and standards, as well as the special status, needs, and rights of children and to ensure that detention is used as a measure of last resort, for the shortest possible period of time, and with the best interests of the

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child as a primary consideration, and that they are handed over expeditiously to child protection actors and civilian authorities in line with the established policies and guidance.

CONDUCT AND DISCIPLINE

10. To hold our own personnel to the highest standard of conduct, and to vigorously and transparently investigate and prosecute, where appropriate and in accordance with applicable national law, or otherwise fully cooperate with the competent authority, any incidents of alleged abuse against children– including sexual exploitation and abuse – by our peacekeepers.

CONTRIBUTION OF WOMEN

11. To recognize the essential contribution of women to peacekeeping operational effectiveness, and the distinct and critical roles of both men and women in the protection of children and the prevention of the recruitment and use of child soldiers.

DISARMAMENT, DEMOBILIZATION, AND REINTEGRATION (DDR)

12. To ensure that child soldiers are included as a priority in the planning and execution of all United Nations supported disarmament, demobilization, reintegration, and, where appropriate, repatriation efforts, taking into account their specific needs, including those based on gender, age, and other identity factors, to assist in their successful transition to normal life, and to prevent their re-recruitment.

MENTAL HEALTH

13. To actively promote and support research on the trauma experienced by personnel confronting child soldiers and interacting with children affected by armed conflict, and to provide appropriate pre-deployment preparation, as well as mental health support during and post-deployment.

PEACE PROCESSES

14. To support the inclusion of child protection provisions within the terms of peace processes, peace agreements, and post-conflict recovery and reconstruction efforts, noting the unique vulnerability and protection needs of children, the importance of their rehabilitation and reintegration into their communities, and the urgent need to prevent and end the recruitment and use of child soldiers to achieve lasting and sustainable peace.

SANCTIONS

15. To support the inclusion of child recruitment and use as a designation criterion in United Nations sanctions regimes aimed at supporting the political settlement of conflicts in the context of peace operations.

BEST PRACTICES

16. To share with other Member States and the United Nations best practices and lessons learned on the prevention of the recruitment and use of child soldiers in the context of peacekeeping.

FURTHER GUIDANCE

17. And in this regard look forward to the development, in consultation with Member States, the United Nations, and child protection actors, of operational guidance for the implementation of these Principles.

FURTHER INFORMATION

Further information about the 2017 Peacekeeping Ministerial may be found at the following address: https://www.canada.ca/en/department-national-defence/campaigns/peacekeeping-defence-ministerial.html

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